FINANCING THE HEALTH CARE SAFETY NET:

HOW FEDERALISM AND MEDICAID'S FUNDING FORMULA SHAPE STATE BUDGETS AND AMERICAN WELFARE

by

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ABSTRACT

Financing The Health Care Safety Net: How Federalism And Medicaid's Funding Formula Shape State Budgets And American Welfare

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This dissertation explores the political development of Medicaid financing, specifically its federal-state cost sharing formula. This dissertation traverses a half-century of congressional policymaking and an original 30-year dataset of state-level Medicaid expenditure and enrollment figures to provide a positivist account of how the federal and state governments' shared financial responsibilities for Medicaid affect overall Medicaid expenditures and state budget priorities. This dissertation also considers the direct and indirect financial burden that Medicaid's costs impose on taxpayers—both in their capacity as Americans and as residents of individual states.

This dissertation argues that the growth in Medicaid costs is attributed to the resiliency of a funding formula that subsidizes the states' policies and redistributes liability for Medicaid expenditures between the states and federal governments. By subsidizing the costs of a state's Medicaid program, a state's Federal Medical Assistance Percentage (FMAP) reduces the effective fiscal burden of its Medicaid policies, thereby incentivizing policymakers to expand Medicaid beyond what is warranted by the policy preference of the state's residents. As a result, state budgets are likely to reflect an intentionally inefficient, yet politically rational, allocation of public resources. Compounded over decades, and exasperated by more recent adjustments that reduce the states' direct fiscal responsibilities for their Medicaid policies, the fiscal imperative imposed by Medicaid's financing institution has compelled states to maintain a rate of growth in Medicaid expenditures that now threatens to overwhelm the states' ability to adequately fund its other public commitments.

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SECTION I. INTRODUCTION AND OVERVIEW

Chapter 1. Introduction and Overview

Medicaid—Title XIX of the Social Security Act of 1965—is the nation's federal-state program of non-contributory, means-tested health insurance for the poor and near poor. Despite being burdened by the stigma of public assistance and pejoratively described as "welfare medicine," Medicaid has quietly become an essential and resilient component of both the United States' health care delivery systems and its social welfare state. While many public health scholars and welfare advocates still lament its purported second-class quality, Medicaid is unusually generous for an American welfare program, both in terms of the expansiveness of its coverage and benefits—in 2011, the states and federal government combined to spend $425 billion on Medicaid/CHIP to provide health insurance to over 65 million individuals, about 1 in 5 Americans. On average, Medicaid spending consumes about a quarter of all state budgets and nearly half of all federal grants provided to the states; it is the nation's most expensive domestic program financed from general revenues, with the average state now spending more public monies on Medicaid than they do on K-12 education (National Association of State Budget Officers, 2013). Medicaid's expansion over the past half-century has been remarkable. The Affordable Care Act of 2010 hastens Medicaid's expansionary tendency and will no doubt increase the program's salience: an additional 15-25 million Americans are anticipated to eventually be enrolled in the states' Medicaid programs at an added cost to the states and federal governments of at least $100 billion once fully implemented.

With respect to either Medicaid's societal impact or its public costs, it is no exaggeration to characterize the program as the most consequential of all intergovernmental programs, if not of all domestic programs in general. To better understand the magnitude of the nation's Medicaid commitments this dissertation emphasizes Medicaid's public cost by exploring the political development of its financing

mechanism. Specifically, I explore how fiscal federalism—the federal and state governments' shared financial responsibilities for Medicaid—impacts overall Medicaid costs and the fiscal burden that the program imposes on the states and taxpayers (both in their capacity as Americans and as residents of individual states). Using over half century of qualitative observations and quantitative data, I provide an original positivist account of the political development of Medicaid cost sharing and describe how this financial institution impacts state and federal budgets.

In this dissertation I argue that the unbridled growth in Medicaid costs can be attributed to the resiliency of a funding formula that subsidizes the states' policies and redistributes liability for Medicaid expenditures between the states and federal governments. By subsidizing Medicaid costs, the federal government's matching rate—as determined by the Federal Medical Assistance Percentage ("FMAP")—reduces the fiscal burden of a state's own Medicaid policies, thereby incentivizing policymakers to expand Medicaid beyond what is warranted by the policy preference of the state's residents. As a result, state budgets are likely to reflect an inefficient allocation of public resources. And yet, paradoxically, supporting this inefficient prioritization of Medicaid is rational from the perspective of the states. Compounded over decades, the fiscal imperative of Medicaid financing has compelled states to maintain a rate of growth in Medicaid expenditures that now threatens to overwhelm the states' ability to adequately fund its other social obligations and maintain reasonable tax rates. Given the still ever-increasing proportion of state budgets that are being committed to Medicaid and with the Affordable Care Act of 2010 significantly extending Medicaid's model of fiscal federalism—and doing so at an unprecedentedly generous level—it is essential that the public becomes better informed about how Medicaid's funding formula can perniciously influence the priorities of state policymakers and thereby public budgets. This dissertation explores how the

comparatively low fiscal burden of the states' Medicaid programs—relative at least to the full cost of Medicaid—shapes the American welfare state and the social priorities of the states.[1]

This dissertation is intended to help researchers, policymakers, and the public better appreciate the anomalous nature of the nation's fiscal commitment to Medicaid. In general, efforts to provide an explanation for the states' Medicaid programs, either in relationship to either the American welfare state or within the context of the broader health care sector, including Medicare, have proved elusive. In approaching Medicaid from the perspective of welfare policy, Jonathan Engel, for example, begins his history of Medicaid with the typical observation that American's "ambivalence toward charity medical care mirrors its historically ambivalent commitment to poor relief generally." Describing Medicaid as a "tepid" policy that is exemplary of the meagerness of the nation's other means-tested programs, Engel uses the states' programs to argue, "America has proven itself consistent, if not compassionate" (2006: xi). Yet, Engel's comparison of Medicaid and AFDC/TANF seems strained. The much-maligned cash assistance program provides support to fewer than 4.5 million Americans a month at total cost of about $33 billion in 2011. Comparatively, whether measured in terms of costs or enrollment, Medicaid is more than ten times the size of AFDC/TANF. Engel's characterization emphasizes the significance of perspective and exhibits a

[1] I refer to both the "costs" and "fiscal burden" of Medicaid in reference to the national and state-level financial commitments to the program. The distinction is intentional and necessary. "Cost" alone is too generic a term for describing the budgetary implications of fiscal federalism and the political economics of Medicaid. Without imposing a normative standard for what constitutes a "burdensome" level of spending, I employ the notion of "fiscal burden" to differentiate between the full cost of a Medicaid policy and its cost to the states. Fiscal burden is therefore synonymous with the cost of the state share. For example, if a proposed reform is expected to cost $100 million, but the state benefits from a FMAP rate of, say 65%, the actual fiscal burden that the state incurs is just $35 million. The $65 million subsidy must still be financed.

Related, in Chapter 6, I will refine the definition of fiscal burden to consider "taxpayer burden" and the actual liability it imposes on American taxpayers. Similar to how fiscal burden is a measure of only that share of Medicaid expenditures that a state must directly finance from its own revenue sources, taxpayer burden proxies the actual cost of Medicaid from the perspective of American households at different income levels.

common bias of health care scholars toward a preference for the more ambitious goal of universal access to public health care—a legitimate goal, but one that, for most, was never the intent of Medicaid.

In contrast to Engel's critical assessment of the health care safety net, Lawrence Brown and Michael Sparer (2003) characterize the evolution of Medicaid over the decades as a Cinderella transformation. Rather than perceiving the states' Medicaid programs as callously insufficient welfare solutions that are emblematic of the nation's failure to guarantee health insurance to all Americans, Brown and Sparer characterize Medicaid as an atypically resilient and successful means-tested program for the nation's most vulnerable citizens. In their thoughtful comparison of Medicaid and Medicare, Brown and Sparer argue that "the conventional wisdom about the political inferiority of poor people's programs…misses much" and conclude that the Medicaid is "not so poor a program after all" (2003: 34, 43). I approach Medicaid from this perspective: rather than perceiving Medicaid to be another tepid welfare program and comparing it to the nation's other redistributive welfare programs, I recognize Medicaid as being uncharacteristically generous in the context of American welfare programs—providing tens of millions of Americans with access to noncontributory and comprehensive health care.

The peculiarity and salience of Medicaid justifies its centrality to this dissertation.[2] While understanding the cause and effect of differences between different social programs is necessary and can improve our understanding of both programs, this is not the objective of this particular project. Despite the existence of many rich histories on Medicaid policymaking that comparativists can leverage, the literature

[2] For example, given that the primary objective of this dissertation is to understand the impact of fiscal federalism on the growth of Medicaid budgets, framing it as comparative study of Medicaid and Medicare would be of limited value. Despite their similar genesis, as mechanisms for the public financing of health care services, Medicare and Medicaid exhibit more differences than similarities. Unlike the joint federal-state administration of Medicaid, Medicare is an exclusively federal program. And whereas Medicare is an entitlement program available to all Americans, or their spouses, who have paid sufficient payroll taxes, Medicaid is a non-contributory, means-tested welfare program.

on Medicaid is not saturated. The primary objective of this dissertation is to understand the affect of fiscal federalism on the size and growth of Medicaid budgets. To that end, this dissertation includes original archival research and an analysis of an original dataset, efforts that can benefit future comparative work on other means-tested programs, health care payment models, or public financing, among other topics.

Caveat Emperor

Throughout this dissertation I emphasize the high level of spending that the nation commits to Medicaid. I do not propose a normative standard for what constitutes an ideal amount of state spending for the program, but I am critical of the manner in which Medicaid budgets are set. Without diminishing the real needs of the poor for the essential health care services that Medicaid offers, I argue that the magnitude of public spending committed to the Medicaid program reflect an inefficient allocation of public resources and does not respect the public's true policy preferences for the welfare state. Given the base assumption that Americans taxpayers prefer a modest welfare state I uncritically conclude that the nation's spending on Medicaid is *ipso facto* sub-optimal. This anomalous outcome is an intentional result of Medicaid's funding formula as the federal-state cost sharing sustaining compels state policymakers to pursue expansionary reforms. Paradoxically, as I will demonstrate with using the game theoretic model known as the prisoner's dilemma, such policies are simultaneously rational and inefficient from the perspective of the general public's budgetary priorities.

No doubt, many will counter that an expansive (and expensive) Medicaid program is more equitable than the alternative. That may be true. However, neither efficiency nor optimality is synonymous with equitability. "Political economy does not have to take morality into account," warned Vilfredo Pareto himself (1906: 13). Taking this perspective, this dissertation is not a commentary on the effectiveness or equitability of Medicaid spending. I do not ruminate upon whether or not the end justifies the means.

Overview of Dissertation

The myopic attention of this dissertation toward Medicaid policymaking reflects the policy's magnitude and its unique relationship to the American welfare state. With Medicaid likely to remain the fastest growing component of state budgets, particularly given the role that Medicaid has for the nation's

health reform agenda, it is critical that the public, government officials, and academics, better understand its budgetary implications. As Frank Thompson and Thomas Gais (2000: 136) describe it, Medicaid is "the elephant in the living room that cannot be ignored by political officials and key interest groups"—nor academics. To understand Medicaid's political development, I employ a mixed methods approach that takes seriously Paul Pierson's counsel: "To be persuasive, accounts of welfare state change must combine macroscopic and microscopic analysis" (Pierson 1994: 13). By combining a historical narrative that surveys a half-century of policy debate with a statistical study that analyzes an original dataset of state-level Medicaid expenditure data, this dissertation offers a comprehensive examination of the institutional determinants for Medicaid's exceptional costs.

After presenting an outline of the subsequent sections, the remainder of this preliminary chapter will introduce the main bodies of literature that I reference, draw assumptions from, and for which I hope to make my own contributions. The associated research areas include: American political development; interest group politics; the welfare state; state politics and federalism. Borrowing from the analytical approaches, substantive insights and theoretical perspectives often developed independently by each of these bodies of literature, this dissertation looks to offer an explanation for the anomalous nature of Medicaid and challenge some of the discipline's base assumptions about American politics—including the weak welfare state thesis and the supposed inherent weakness of poor people's programs in the United States. I conclude this introductory chapter with a general overview of the federal cost sharing formula used to underwrite Medicaid—the Federal Medical Assistance Percentage ("FMAP")—and a discussion of the game theoretic model known as the prisoner's dilemma. I use the model to support my theoretical argument that Medicaid's funding formula compels states to expand Medicaid and implement sub-optimal policies. The abstracted formal model helps describe the reasons for why, within a context of federal cost sharing, it may

be rational for policymakers to support the continued growth of state Medicaid programs, even if the nation's overall budgetary commitments to the program conflict with the public's true preferences.

Chapters 2 through **5** constitute **Section II** of this dissertation and reflect the core of my qualitative historical narrative. These chapters trace the institutional and political development of the federal government's financial participation in, and the states' commitments to, Medicaid, from the enactment of the Social Security Amendments of 1950 through to the Affordable Care Act of 2010 (ACA). By leveraging congressional committee reports and floor debates, contemporaneous news accounts, and secondary literature, this original narrative emphasizes Medicaid's fiscal underpinnings and the political development of the FMAP funding formula used to define the cost sharing arrangement between the federal and states' governments. From its initial implementation the funding formula has remained remarkably stable. The history suggests the resiliency of the funding formula used for calculating the states' FMAP can be attributed to the ambivalence by public officials toward the fiscal implications of Medicaid's funding formula, as well as, the general recognition by state and federal lawmakers of the effectiveness of distributing fiscal burden across levels of government to encourage spending. While state and federal officials, alike, will voice their concerns about the sustainability of Medicaid's fiscal burden and high costs, only modest adjustments to the financial arrangement have been made over its history, and each time the reforms have been in the direction of lessening the state's fiscal burden. Specifically, incremental reforms beginning in the 1990s reflected a concession by Congress and acknowledgement that Medicaid spending was crowding out other public needs. Yet, the states continue to commit ever-greater proportions of their limited budgets to Medicaid. The full federal funding of the Medicaid expansion included in the ACA and beginning in 2014—to be reduced to 90 percent of costs by 2020—reflects the opinion held by federal lawmakers that Medicaid, as currently financed, is unsustainable for the states.

This general history of Medicaid financing emphasizes how the federal government's mitigation of the states' fiscal burdens has motivated every state to commit a large, and ever-increasing, proportion of their resources to their Medicaid commitments. However, it must be noted that the extent and nature of the states' Medicaid expansions have not been consistent across the nation. In fact, from the perspective of certain indicators—including a state's total Medicaid costs, spending per recipient, and eligibility criteria—relative variation in the states' Medicaid programs has increased over time. Remarkably, after nearly half-century of Medicaid policymaking there has been no lessening of the degree of variability in the states' fiscal commitments to their Medicaid programs.[3] The subsequent section explores this persistent variation in the state-level implementation of Medicaid, with its two chapters exploring what Michael Sparer documented as the "inappropriate and inequitable variation" in Medicaid programs across the states (1995: 194).

Section III is the quantitative component of this mixed methods dissertation. It employs an original dataset that I constructed from three decades of archival data on Medicaid expenditures and enrollments from the Center for Medicare and Medicaid Services, as well as various other governmental resources, including the U.S. Census, the Bureau of Economic Analysis, and non-profit entities, such as American Hospital Association and Kaiser Family Foundation. Such an expansive set of state-level data on Medicaid spending has never been created but is necessary for performing sufficiently robust time series models of the social-economic-political determinants of Medicaid policymaking.

Chapter 6 represents a longitudinal macro analysis of state-level data from the fifty states over three decades, from 1980 through 2008. For the analyses I construct proxies for the three major components of Medicaid policymaking, which taken together epitomize Harold Laswell's (1941) old

[3] For example, in 2008, the mean level of expenditures across the nation was approximately $1,150 per capita; but, 5 state and the District of Columbia spent more than $1,750 per capita on Medicaid/CHIP (inclusive of administrative and DSH payments), with New York and DC budgeting the most at around $2,500 per capita, while another 5 states spent less than $750 per capita, with Nevada budgeting the least at just over $500 per capita.

definition of politics as the determination of who gets what and for how. These proxies—that I refer to as *coverage*, *benefits*, and *cost*—reflect *who* will be eligible for Medicaid, *what* health services their Medicaid program will cover, and *how much* from the state's revenues they will spend on Medicaid. While the poor may wish to maximize *coverage*, and providers are likely to lobby to maximize their *benefit* payments, the public, particularly the taxpaying public, is likely to be most concerned about the overall *cost*. The quantitative models test numerous predictors on these three components of the states' Medicaid programs. However, despite significant variation in each of the dependent variables across the entire time period and contrary to expectations, no strong relationships can be discerned from the time series analysis suggesting that other dynamics may be unaccounted for in the study. Although the absence of any explanatory smoking gun that could explain the variation in Medicaid programs at the state level is admittedly unhelpful from the perspective of developing a succinct theory about America's surprising welfare state, the results are consistent with the sentiment that Medicaid programs are esoteric. "If you understand one state's Medicaid program, well, then, you understand *one* Medicaid program," explained one Medicaid consultant who had experiences working on multiple state Medicaid programs.[4]

Chapter 7 focuses exclusively Medicaid spending in fiscal year 2008 in order to understand how the progressivity of both the FMAP funding formula and the federal tax code impact Medicaid's effective fiscal and taxpayer burdens. Using Medicaid expenditure and state- and federal-level tax data from the I.R.S. and Tax Foundation, I calculate variable metrics of what: (a) taxpayers, both as Americans and as residents of a particular state, contribute to Medicaid, and (b) states as sovereign entities pay to finance the Medicaid program relative to the value of the services the state actually receives. With a few adjustments to

[4] In 2012 and 2013 I served as Senior Policy Analyst and then Manager of Policy and Research for the Connecticut Health Insurance Exchange, a quasi-public agency responsible for implementing part of the Affordable Care Act in Connecticut. My job brought me into frequent engagement with not only Connecticut's Department of Social Services (the state body responsible for administering Medicaid) but also consultants and officials responsible for health policy, including Medicaid reform, from several others states.

reflect the contribution of various funding sources, this chapter's calculation of the direct and indirect costs of Medicaid suggest in most states, many residents get a high value of the services delivered for their investments in their state's Medicaid program.

A brief conclusion, **Chapter 8**, summarizes the preceding chapters and an **epilogue** considers the potential impact of the Patient Protection and Affordable Care Act of 2010 ("ACA") on the future of Medicaid and Medicaid expenditures. With the massive Medicaid expansion included in health reform almost entirely funded with general revenues from federal government the law continues the trend of lowering the states' fiscal burden for Medicaid. Reducing the states' financial responsibility for Medicaid has the potential to diminish the states' incentives to control their expenditures.

Theoretical Foundation in the Literature

This dissertation will appeal to a variety of subfields within political science and will draw broadly from departments of history, public policy, public health and social work, and economics. It has been enriched greatly by the breadth of substantive policy research on Medicaid that is already available: public health academics have provided at least partial descriptions of a number of state Medicaid programs; government institutions and research bodies have produced detailed reports on effectiveness of Medicaid on improving the health of the poor and dealing with the problems of the uninsured; economists have analyzed the differential costs of the various populations enrolled; journalists have objectively reported on the debates surrounding the growth of Medicaid expenditures and its reforms. Beyond the substantive appeal of these many resources, the following literatures provide important methodological and theoretical foundations for the research that follows.

State Politics and Federalism

This persistent variation exhibited by the states' Medicaid programs challenges political scientists' classic theories of federalism and policy adoption—both the cynical race-to-the-bottom hypothesis often associated with redistributive policies and the more optimistic state-as-laboratories thesis of policy innovation and the spread of successful reforms. And given that Medicaid is the nation's largest intergovernmental welfare program, its incongruence with the expectations of traditional theories of state politics should motivate scholars to reconsider the validity of those theories. The latter half of this dissertation offers original archival research and an original dataset that could service academics pursuing test cases for these two theories that dominate the federalism and state politics literature.

The states-as-laboratories thesis justifies variation across the states as a reasonable and, even, desirable alternative to the inflexibility that would otherwise result from its administration being fully ensconced in Washington. Federalism, and the programmatic flexibility it grants to the states, allows states to experiment with their Medicaid policy design and implementation. As the promulgation of Medicaid managed care and various Medicaid waivers demonstrate, states have demonstrated their ability to learn from each other's experiences with Medicaid to implement what is perceived to be a more efficient health care safety net for their poor residents. Yet, a reprise of recent studies on state politics and the idea of states as "laboratories of democracy" did not include any mention of research pertaining to Medicaid, specifically, nor health policy and politics, more generally (Moorehouse and Jewel 2004). This is a stark omission given the fiscal, political and bureaucratic pressures that Medicaid and CHIP impose upon state politics and the important supplementary, if not primary, responsibility that states have in the overall delivery of health care in the nation.

Of course, Medicaid has not been completely overlooked by political scientists studying state politics. For example, Craig Volden (2006) looks at the design of the states' CHIP programs to test for the strategic interaction of states. Volden and others' work on policy diffusion provide valuable theories on policy learning across states that are applicable to the political calculus of Medicaid reform (Volden et al. 2008). In contrast to Volden's optimism for policy learning driving innovation, Michael Sparer is dubious of the states-as-laboratories thesis as a justification for federalism, especially in relationship to the prolonged variation between state Medicaid programs. Failing to find a normative or ethical justification for interstate inequity present in Medicaid, Sparer argues instead that it demonstrates that states "are not especially good policy laboratories" (1996: 9; see also Sparer and Brown 1996; Oliver and Pal-Shaheen 1997; Peterson 1997; Oliver 2001; Thompson and Burke 2007; Baughman and Milyo 2008; and, more generally: Walker 1969; Gray 1973; Berry 1994; Volden et al. 2008).

The flipside of the laboratories thesis is a more pessimistic artifact of American federalism: the race-to-the-bottom ("RTB") thesis. RTB presupposes that the interstate competition between states reduces the potential progressivity of state tax systems (Kincaid 1991; Duncan 1992), thereby limiting the fiscal capacity of state governments to implement robust social welfare programs. Among other consequences, Michael Bailey and Carl Rom (2004) hypothesize that threats of RTB will negatively impact the ability of the state to offer redistributive policies benefiting the poor. Given the high cost of Medicaid from the states perspective and the high benefit that a recipient could receive by migrating to a state for the purpose of becoming eligible for Medicaid, the policy should be an easy test for the validity of the RTB thesis. And yet, despite Medicaid's status as a means-tested welfare program, the universal marginalization of Medicaid anticipated by the theory has not occurred. Not only do such traditionally accepted liberal states, such as California and Connecticut, retain significantly more generous eligibility standards than their neighbors, so do more conservative states like Arizona and Arkansas.

Overall, the Medicaid data supports neither a regression to the mean that could suggest potential policy learning, nor the precipitous downward trend toward the lowest common denominator as predicted by RTB. Rather, with state-level empirics that exhibit a degree of inter*state* variation that is comparable to inter*national* differences in healthcare policies, Medicaid offers strong evidence for Christopher Howard hypothesis "that there is no single American welfare state—that instead there are two or more American welfare states" (1999: 439).

Interest Group Politics and Public Opinion

Clem Brooks and Jeff Manza (2007) argue that the design of a nation's welfare policies is generally influenced by the "embedded preferences" of its public. Although economic calculations may impact public opinion towards the size of the welfare state, Brooks and Manza argue that the public's base policy preferences are "embedded" in a country's—or in the instance of Medicaid, a state's—social structure, major institutions, and collective memory. Of course, the idea that policies reflect, however imperfectly, public opinion grounds most theories of democratic representation. Yet, Brooks and Manza's theory of embedded preferences gives greater agency to ideology and public opinion than do theories of path dependency and institutionalism, which privilege institutions and elites (Hacker 2002; Pierson 2003; see also, Baumgartner and Jones 1993, 2002). Given the commonality of Medicaid institutions across all the states, Brooks and Manza theoretical framing of the importance of public opinion offers a causal story and a potential explanation for both the observed variation across the fifty states and the year-to-year instability in the 50-state rankings of total Medicaid spending. Incidentally, as the largest means-tested program in a state budget, the states' Medicaid commitments could be a good proxy of a state's general level of support for the welfare state and, thus, offer useful evidence to substantiate Brooks and Manza's research.

In contrast to the public's likely knowledge for the overall size and cost of government (of which Medicaid is a major component), the public is less likely to be aware of the programmatic specifics of Medicaid, including its covered benefits and reimbursement rates. As such, marginal changes and variations in state benefits are likely to be better predicted by mechanisms other than public opinion, such as interest groups politics, legislative entrepreneurship, policy delegation and administrative discretion. There is extensive literature on the lobbying influence of interest groups on public policy (Baumgartner and Leech 1998; Gray and Lowery 2001; Tichenor and Harris 2005; Moe 2005). With respect to health care, Mark Peterson (2001; also Hammer *et al.* 2003) persuasively argues that an asymmetry of information advantages providers. James Morone, in the introduction to a volume on the politics of health care policy, notes an uneven influence in the medical community that favors the organized: "The surgeon general, the Institute of Medicine, and the Centers for Disease Control and Prevention might issue warnings based on good science. However, any effort to act on those findings simply triggers the politics of self-interest," observed Morone—with "self-interest"—be it economic or electoral—being "every bit as legitimate as medical science" (Morone 2005: 14).

The fate of the United States Preventive Service Task Force's (USPSTF) recommendation on breast screening exemplifies how the emotional appeal of health care can foment public opinion and triumph in politics. It is a perfect example to prove Monroe's observation that "your science is only as strong as your political coalition" (2005: 15). In 2009 the USPSTF—a panel of medical experts appointed by the Department of Health and Human Services—recommended that women begin routine screenings at age 50, as opposed to age 40. This was a simple reform that could improve the nation's health while, incidentally, saving hundreds of millions from the nation's health expenditures. Congress' incredulous response to the recommendation was to not only ignore and mischaracterize the panel's research, but to

create an expensive new federal entitlement that required all insurers to fully subsidize the very treatments the panel had cautioned against.[5]

Policy Studies

The policy studies literature is rich with work that considers Medicaid. David Smith and Judith Moore (2008) offer an excellent reference for those interested in the political history of Medicaid policy. It is an important complement to host of other work by political scientists and political historians, such as the more general work on Medicaid and charity care by Jonathan Engel (2006) or David G. Smith's (2002) work on the politics of Medicare and Medicaid following the Gingrich revolution (for more general political histories of American medicine see also, for example, Starr 1982; Hacker 2004; Weissert and Weissert 2006; Patel and Rushefsky 2006, 2008). However, much of the existing Medicaid research, even that which discusses the politics of devolution, examine Medicaid and American health care almost exclusively from

[5] Congress responded to the USPSTF recommendation by summoning, Ned Calogne and Diana Petitti, the chair and vice chair of the USPSTF, to a hearing before the House's Energy and Commerce Health Subcommittee. Politics dominated and it became clear that the Task Force's recommendation was peripheral to the larger political debate over health reform. During hearing Rep. Michael Burgess (R-Tex.) referred to the health reform bill as "the 2,000-page gorilla in the room" and Rep. John Shimkus (R-Ill.) assured that the breast cancer screening guidelines "will not be taken outside of the context of the H.R. 3962 [the Houses' health reform bill]" (U.S. House Energy and Commerce Health Subcommittee, 2009).

Although Dr. Calonge admitted it was poor timing to release the recommendation while Congress was engaged in a bitter debate over health insurance overhaul he assured the representatives that, "Politics play no part in our processes." Yet despite such assurances, nearly everyone responded to the non-partisan medical report with unsubstantiated fears of rationing: --"It's just kind of a peek under the curtain, if you will, of what we can anticipate with a government-run program," observed Sen. Lisa Murkowski (R-Alaska). --"This is when you start getting a bureaucrat between you and your physician. This is how rationing begins," Rep Marsha Blackburn (R-Tenn.) added. --Even the administration was quick to distance itself from the Task Force. The recommendation has "caused a great deal of worry and confusion among women," Secretary Kathleen Sebelius said in a statement, adding that USPSTF "won't determine what services are covered by the federal government" (Olmos and Waters 2009).

Subsequent to the hearing, the House voted 426-0 for a nonbinding resolution (named after Rep. Debbie Wasserman Schultz (D-Fla.), a breast cancer survivor) and the Senate passed under unanimous consent an amendment (proposed by Sen. David Vitter (R-La.) whose wife, at the young age of 6, had lost her own mother to breast cancer) that effectively required the federal government and all private insurers to ignore the Task Force's recommendations and promised expanded first dollar coverage for mammograms.

the federal level or generalizes to the states in a manner that presents a unitary impression of the implementation of Medicaid policies at the state-levels. Admittedly, my dissertation, too, emphasizes the role of the federal government, specifically, the relationship of the federal matching formula on Medicaid's resiliency and growth. However, this dissertation is fundamentally about the impact of the evolving fiscal relationship between the federal government and the states, and how that relationship impacts the state-level implementation of Medicaid.

The narrowing of my substantive perspective to Medicaid's financing arrangements is a response to Christopher Howard's (1999) critique that the discipline of political science has a tendency for wheel spinning among tried and tested theories in explaining the politics of the nation's welfare state. He contends these theories suffer from analytical exhaustion. In Howard's review of the field, he observes that the "substantial gaps separating studies at the national level and studies at the state and local levels…produce dubious generalizations about the structure of the American welfare state and incomplete explanations for its development." (1999: 421) In particular, Howard's review uncovered that "developing mid-range generalizations limited to social policy has simply not been a priority at the state level" (Howard 1999: 421). Such a tendency has led certain social programs, Medicaid included, that do not fit neatly into the archetypes of American politics and its welfare state policies—by which I mean the increasingly challenged abstraction of a two-tier national welfare system that differentiates between the deserving and undeserving poor[6]—to be overlooked or not sufficiently interrogated by the discipline. Referring explicitly to Medicaid, Howard aptly noted, "As a general rule, when the largest single element in a category does not fit, it is probably time to rethink the category." (1999a: 428).

[6] Christopher Howard's own research on the "hidden" welfare state expanded the discipline's understanding of welfare politics by looking into how tax expenditure policies are used to advance social welfare objectives (see, Howard 1999b). Similarly, Jacob Hacker's theorizing on the "divided" welfare state looks at the involvement of the private sector in the development of social welfare policies (see Hacker 2002). Both of these work focus exclusively on national level politics.

With an emphasis on Medicaid financing, this dissertation does not propose an alternative to the notion of a two-tiered welfare state. However, the historical narrative and state level empirics should appeal to academics, myself included, seeking to develop a better paradigm for understanding the charitable relationship of the public, their elected officials, and political institutions to the welfare state. For example, the growth of Medicaid fits into a general trend, highlighted by the parallel expansions of the Earned Income Tax Credit and Food Stamp programs, that suggests Americans have come to acknowledge the working poor as deserving of public assistance (inclusive of health care) as the elderly, children, and mothers.[7]

I see four reasons why political scientists have not traditionally put policy under the microscope. First, policies are complex with any specific instance of a policy reflecting compromises and an ordering of individual preference that are inherently unstable. The social-choice paradox of Arrow's Impossibility Theorem (1951) that, to paraphrase, asserts no rank ordering of preferences can be discerned given more than two choices (and a fair voting system), makes policy analysis unattractive for the discipline. This is particularly true for rational choice scholars searching for a deductive general equilibrium or statisticians hoping to identify predictable relationships. Policies and lawmaking exemplify why political science is

[7] This study focuses almost exclusively on the financing of Medicaid. It does not explore an explanation, for example, the comparative fate of AFDC, or any other social welfare program. The differences in the growth and political resiliency of Medicaid and AFDC cannot be explained by their respective financing mechanisms, which up until 1996 were largely comparable (i.e. non-capitated federal match for the cost of state policy decisions). I suspect that the differences between AFDC and Medicaid may be best understood by first examining the differences between AFDC and the Earned Income Tax Credit program, another popular social welfare program, and then by looking at the similarities between Medicaid and EITC. AFDC never exhibited the symbiotic relationship with employers, the labor market or general economy that do EITC and Medicaid.

AFDC (now TANF) is a cash assistance program limited to people who, for the most part, did not work. In contrast, EITC serves as a cash supplement to low-wage workers. As such, EITC socializes an employer's direct cost of hiring low-wage labor, by effectively raising the nation's minimum wage through a negative income tax subsidized by *all* higher income earner. Similarly, Medicaid socializes the cost of what had traditionally been seen as a maternal responsibility of employers and a component of their expected fringe benefit costs. These parallel expansions of the safety net have allowed employers to reduce their costs for certain workers with impunity.

known as the "the dismal science" (Riker 1980). Instead studying public policies, theorists study the institutional structures (e.g. a funding arrangement between states) in which political actors must define their policy preferences and through which some degree of stability is induced by the aggregation of individual preferences (Shepsle 1979; Riker 1980). Second, the balkanization of the discipline has encouraged political scientists to focus on either a specific type of institution or on specific types of political behavior outside those institutions. Well-behaving institutions and publics become the variables to be understood by the researcher. Policies themselves are discounted as ephemeral solutions to parochial debates: policies reflect, rather than modify, formal political processes; they adapt to, rather than shape, processes of historical change. Third, policies are very difficult to quantify. While programmatic expenditures are the most objective measure of a government's relative fiscal commitments to individual policies, measuring the relative effectiveness of policy implementation is fraught with empirical uncertainty. Discovering good measurements for the many the different dimensions of specific policies is time consuming and requires significant trial and error.[8] Finally, most political scientists are not policy analysts, and nearly as many would argue that they should not claim that role as academics. Academics are neither technocrats nor moralists and it is not the discipline's responsibility to editorialize the effects of policy.

Yet, as William Epstein correctly observes the influence of political power and impact of institutions and cannot be known, "except through their proximity to policy choice" (Epstein 1997: 29). Such recognition underlies his critique of the purported "objective truth," "disciplinary formalism," and "politically tempered solutions" of his professional colleagues (1997: 10). My own perspective is less cynical. The public can benefit from the academy's purported objectivism in studying political institutions

[8] For example, in **Chapter 6**, I use spending per recipient as a proxy for the qualitative "generosity" of a state's Medicaid's benefits, but, as I will discuss in the chapter, the variations could be due to the expansiveness of benefits being offered, the level of reimbursements, utilization rates of the beneficiaries, or cost sharing required of recipients, among other potential causes.

and their impact on public policy, even if the truth of it incorporates some subjective biases (e.g. if an academic ascribes to Marxist world view their take on reality will certainly be colored by what they perceive to be an equitable relationship between labor and capital). Motivating my own research is the belief that a better understanding of the development and impact of policy-specific political arrangements, in this instance the financing mechanisms for Medicaid, allows the discipline to contribute substantive insights to policy experts and policymakers.

Research agendas put forward by Pierson (2004, 2005) and Hacker (2005) use path dependency theories to frame public policies as de facto institutions. For these scholars the political development of public policies is constrained by the policy itself. My theoretical lens differs from this exemplary work from the perspective of both our expectations and explanations for policy change and stability. Whereas these new institutionalists give *a priori* significance to the structural determinants and limitations of policy reform, I approach policies from a fundamentally functionalist perspective. I do not believe political institutions are exogenous to the political process. While I recognize potential for conflating political intentions with policy outcomes, I believe that even the unanticipated outcomes of a political institution must continue to effectively serve a coalition of interests. As such, political institutions will persist if and only if they continue to reflect the policy preferences of voters, elected officials and administrators. Medicaid cost sharing does not continue because the FMAP formula is now more than fifty years old, the FMAP formula remains because the status quo (and modest adjustments of it) continues to serve its purpose of incentivizing state participation in the Medicaid.

The Federal Medicaid Assistance Percentage ("FMAP")

This section offers a general overview of Medicaid's funding formula that I argue is foundational to the program's resiliency and is the primary focus of the chapters to follow. A state's Federal Medicaid Assistance Percentage, or "FMAP" rate or "match rate", determines a state's direct cost for its Medicaid commitments. The federal dollars redistributed to the states serve as a subsidy for the states' Medicaid budgets and provide a strong financial incentive for states to expand coverage and/or benefits, especially during boom economics years. Reciprocally, the federal match discourages any reduction in Medicaid because a dollar's worth of cuts to Medicaid coverage or benefits provides only 25 to 50 cents worth of state budgetary savings.

The FMAP formula is a relatively simple, semi-automatic funding formula with no global cap that distributes federal matching payments to the states based on a simple income statistics. It is based exclusively on a three year average of a state's per capita income inversely related to the nation's per capita income. The variable matching rates of the FMAP formula is predicated on the assumption that wealthy states are capable of supporting a greater fiscal burden compared to poorer states. As a state's individual income level increases relative to the U.S. average, the state's FMAP rate decreases, thereby reducing the amount of the state's federal reimbursements as a share of its total spending on Medicaid (i.e. increasing the state's fiscal burden). The quadratic nature of the formula enhances the formula's progressivity and is premised on the principle that the marginal burden of an additional dollar of taxation is less significant for a state with higher level of taxable income relative to a state that has a low income and therefore a smaller tax base. The states' FMAP rates are intended to smooth out the states' total Medicaid expenditures (i.e. costs per capita) by providing larger federal matches to states with fewer resources to tax. Therefore, a wealthy state like Connecticut gets one dollar for every dollar of its own revenues it spends on Medicaid; whereas, a poorer state such as Mississippi receives over four dollars for each dollar it spends from its own sources. This variation is supposed to equalize the tax burden that a state's Medicaid commitment will impose on

state residents. With any federal subsidies, Mississippi and Connecticut spent the same amount on Medicaid and received the same federal subsidy, Mississippi would need to impose much higher marginal tax rates on its residents compared to those required in Connecticut because Mississippi has significantly less economic activity and thus a smaller tax base across which it can spread its public expenditures. So as to encourage a poor state like Mississippi to support an adequately sized Medicaid programs the variable match more significantly reduces the taxpayer burden associated with Mississippi's Medicaid commitment.

Pursuant to Section 1905(b) of the Social Security Act, the formula for the state share is expressed (with a few exceptions) as follows:

$$\textit{state share} = 0.45 \times \frac{\text{State per Capita Income}^2}{\text{U.S. per Capita Income}^2}$$

Therefore, the share of total Medicaid spending by a state that is returned by the federal government to that state can be simply expressed as:

$$FMAP_{state} = 1 - \textit{state share}$$

By statute the FMAP can vary between a 50 percent and 83 percent, the former reflecting the federal commitment to share in at least half of the cost of each state's Medicaid program. In FY 2008, thirteen states were reimbursed at the minimum rate of 50 percent. (Without the minimum threshold on the states' FMAP rates, the matching rates for these thirteen comparatively wealthy states would been, on average, 9 percentage points lower, with the FMAP for Connecticut dropping to a low of 16 percent.) The multiplier of 0.45 that is included in the formula assures that the federal reimbursement rate is 55 percent for a state with income equivalent to the national median; overall, the federal government has consistently financed about 57-60 percent of national Medicaid spending. Mississippi had the highest federal match for FY 2008 at 76.29 percent; Connecticut had the federal minimum with a federal match of 50 percent.

The intent of the FMAP rates is to more-or-less equalize the states' per capita spending on Medicaid.[9] **Figure 1.1** presents a theoretical distribution of state and federal share of Medicaid spending per capita based on the national average of $1,157 in Medicaid spending per capita and the states' actual FMAP rates for fiscal year 2008. The states are ordered by their per capita income along the horizontal axis with their hypothetical Medicaid cost per capita plotted against the vertical axis. The lighter region represents the state share and the darker region is the federal share. For example, if Medicaid costs totaled $1,157 per capita in both Connecticut and Mississippi, the state level charge would have been $579 in the former and $274 in the latter.

Remarkably true to the intention of the FMAP formula the wealthiest state and poorest state in the United States have comparably sized Medicaid programs in 2008: Connecticut's Medicaid program cost a total of $1,298 per capita with the state's share at $649, compared to a total cost of $1,297 per capita and state share of $308 per capita in Mississippi. More frequently, however, the states differ dramatically from each other with respect to their overall commitments to Medicaid. For example, Utah, despite a FMAP rate of 71.63 percent, had the least expensive Medicaid program in 2008 at a cost of $554 per capita with a state fiscal burden of just $163 per capita; comparatively, New York, with a FMAP rate of 50.0 percent, had total expenditures of $2,443 per capita and a fiscal burden of $1,222 per capita. New York's total costs were more than 4 times the level of expenditures in Utah and double the national average. In contrast to the

[9] While the generosity of the federal matching rates has proven to be an effective means to induce every state in the Union to aggressively participate in Medicaid, the cost sharing formula has many noted shortcomings. Specifically, it is generally accepted that the key component of the FMAP equation—per capita personal income—does not accurately reflect the variation in the states' true fiscal capacities to support welfare programs. The nonpartisan General Accounting Office argues that per capita income is "a poor measure of the size of states' poverty populations" and so is a poor measure of state-level redistributive needs. Indeed, the formula gives no consideration to the state-level poverty rate and demographics of the poor population, the health care needs of those poor or the variable state-level cost of providing their health services. As Christie Peters summarizes, "the FMAP formula does not adequately reflect the differences among states' fiscal capacities, concentrations of low-income citizens, or service delivery costs" (2010: 5). For various critiques of Medicaid's regular FMAP formula see: Government Accountability Office, 2003; Miller and Schneider 2004; Granneman and Pauly 2010; Peters 2008; Helms 2007.

hypothetical distribution of liabilities presented in **Figure 1.1**, **Figure 1.2** plots the actual state fiscal burden and total cost of each state for FY 2008, ordering the states along the horizontal by per capita income. The differences between the hypothetical distributions of total cost and state fiscal burden and the actual variability in the distributions thereof are significant. In general, it appears that the FMAP formula is inadequate to ameliorate the differences in the states' commitments to Medicaid. Understanding the potential reasons for the variation in the states' fiscal commitments to Medicaid is an emphasis of **Chapter 6** and **Chapter 7**.

Figure 1.1. Hypothetical Distribution of the State and Federal Share of Medicaid Spending per Resident (based on FY 2008's national average of $1,157 spending per capita and actual FMAPs of the states)

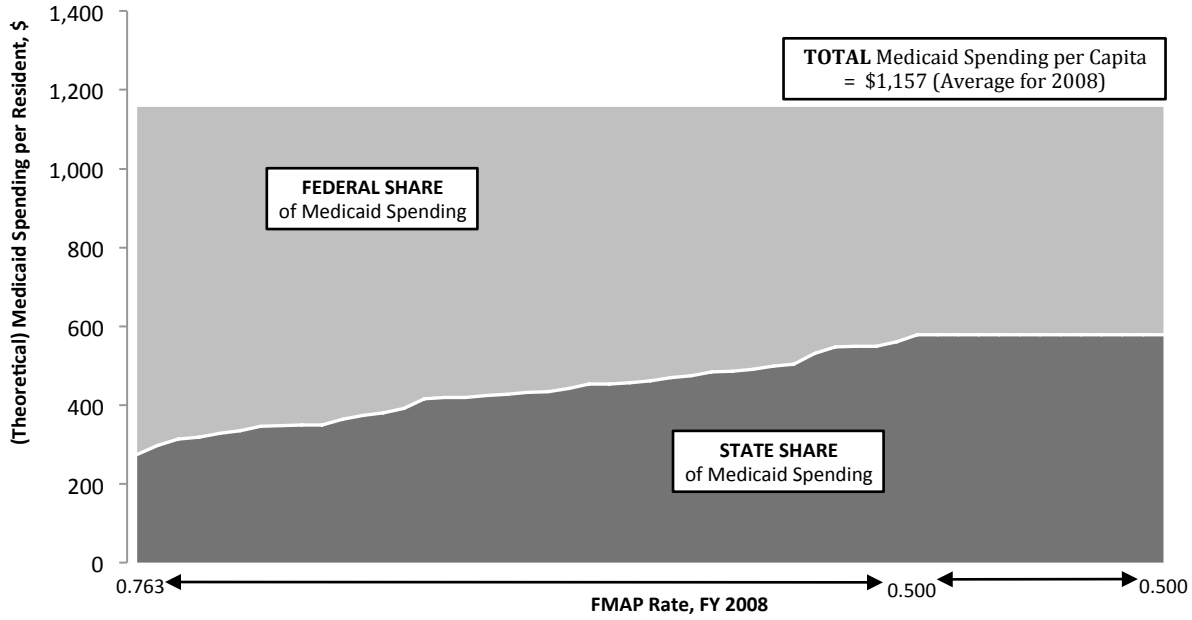
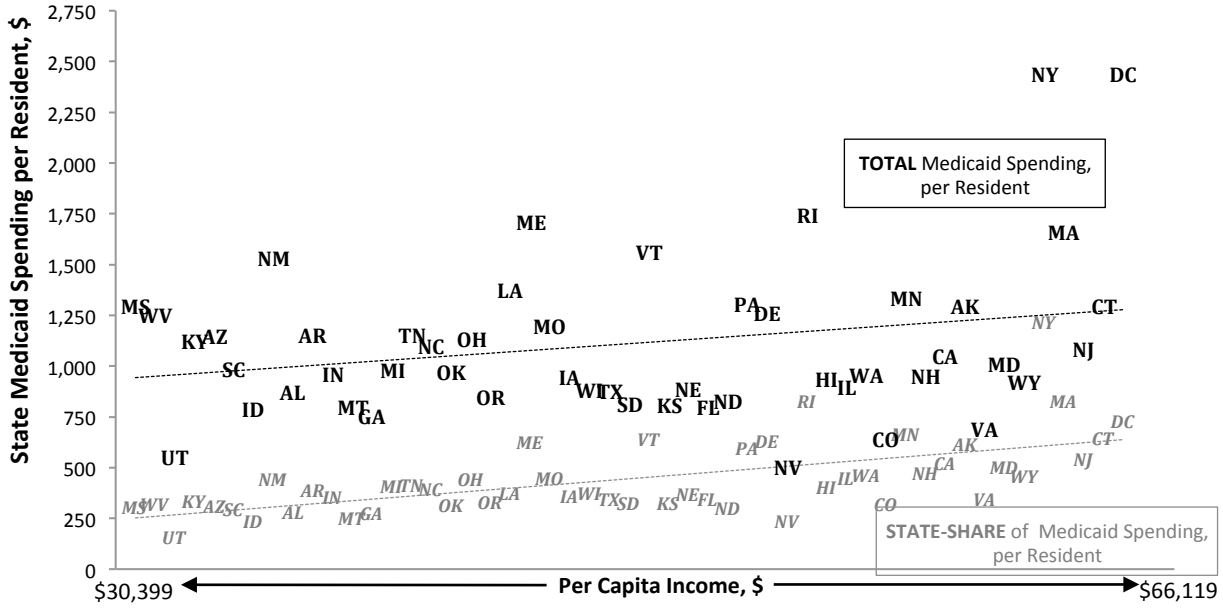


Figure 1.2. Actual Distribution of the State-Share and Total Medicaid Spending per Resident, FY 2008



Theoretical Background: The Prisoner's Dilemma

Before considering the variability in the states' Medicaid programs, however, I explore the political development of the FMAP funding formula and the relationship of this financing mechanism to the nation's overall spending on Medicaid. Throughout the next several chapters I ascribe the inflationary tendency of Medicaid budgets to the federal government's persistent subsidization of the states' Medicaid costs. I argue that federal cost sharing has effectively compelled state policymakers to expand Medicaid over the past many decades. As a prelude to the subsequent historical narrative I conclude this introductory chapter with a causal explanation for the extraordinary nature of the states' Medicaid budgets—adapting the fundamental game theoretic model known as the prisoner's dilemma to Medicaid's financing mechanism.

First, however, it will be useful to review a few concepts of game theory. Game theory is the application of mathematic models to a wide range of behavioral relations. It is used in the study of strategic decision-making. Specifically, in political science, game theoretic models have helped scholars to understand the median voter theorem (i.e. the idea that candidates in a general election will tend to

maintain moderate political platforms) and explain the notion of the democratic peace (i.e. the axiom that democratic nations do not wage war against one another), among many other applications (see McCarty and Meirowitz 2007 for overview of game theory for political scientists).

The prisoner's dilemma is a non-cooperative game used to model circumstances in which rationally behaving actors may nonetheless commit themselves to a suboptimal Nash equilibrium. A Nash equilibrium is an outcome to a game in which no player would elect an alternative action given the choice of the other player; suboptimal implies that their exists at least one other outcome that makes all players at least as well off and at least one player strictly better off. The prisoner's dilemma gets its name from the scenario is describes: two suspects of a crime are apprehended and placed in separate cells where they are interrogated and offered a plea bargain. Each suspect is offered the following deal: if he confesses the prosecutor promises immunity for any testimony that is needed to implicate his accomplice. Such testimony will guarantee that the prosecutor gets the maximum sentence of 10 years for the accomplice. If both suspects confess, however, the prosecutor will no longer need either suspect's testimony against the other and both suspects will get 5-year sentences. If instead of confessing both suspects remain silent the best the prosecutor can do is charge them for a minor crime with a sentence that is less than a year. **Figure 1.3** is a normal-form representation of a 2-player prisoner dilemma representing a matrix of the strategies and payoff for **Suspect A** and **Suspect B**. Along the horizontal axis are the choices available to **Suspect A**; the vertical presents the choices available to **Suspect B**. Each paired choices reflect the outcome of the indicated strategy. For example, from the diagram we can infer that if **Suspect A** confesses and **Suspect B** does not confess, the outcome will be that **Suspect A** will serve no years in jail and **Suspect B** will serve 10 years.

Figure 1.3. Normal-Form Representation of the Prisoner Dilemma

		Suspect A
	Don't Confess	Confess

Suspect B	Don't Confess	*A:* 1 year *B:* 1 year	A: none B: 10 years
	Confess	A: 10 years B: none	A: 5 years B: 5 years

The best joint outcome for the two suspects is for them both to remain silent and each serve the minimal 1-year sentence. This is a Pareto efficient outcome; no solution concept will improve the outcome for *both* suspects. However, the prisoner's dilemma is modeled as a non-cooperative game. With no honor among thieves the strictly dominant strategy for each suspect is to confess. Consider the following strategic decision making from perspective of **Suspect A**:

- If **Suspect B** does not confess, **Suspect A** should confess because he will then serve no time and this is preferable to a 1-year sentence.
- If **Suspect B** confesses, then **Suspect A** should also confess because a 5-year sentence is preferable to a 10-year sentence.

Regardless of the action of **Suspect B**, **Suspect A** should confess. The same strategic options and therefore dominant strategy of confessing apply to **Suspect B**. Unfortunately for the suspects, both confessing is the game's unique Nash equilibrium. The outcome is paradoxical because although it is suboptimal it remains the rational strategy of both suspects.

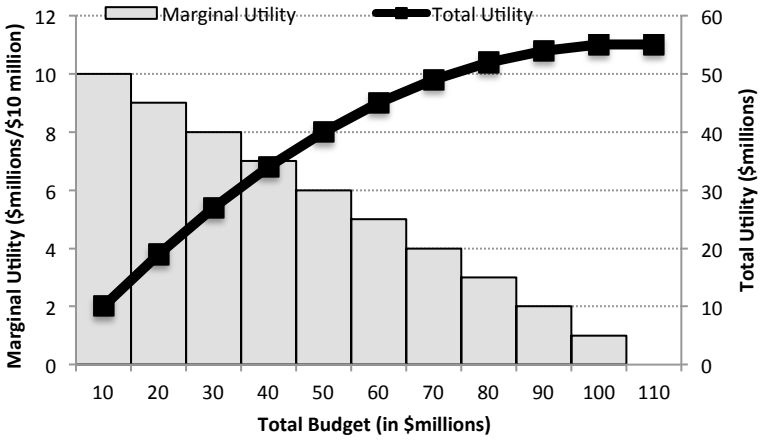
From Bars to Budgets

Now, the prisoner's dilemma may seem like a peculiar analogy for Medicaid, but throughout the dissertation I will present data that suggests the prisoner's dilemma example of a dominant strategy that compels a Pareto inefficient outcome is an ideal theoretical lens for interpreting Medicaid policymaking. Instead of confessing or not confessing, the choice for the states is whether or not to expand their Medicaid budget. The payoff is not measured in years, but in the net benefit of the investment for the state. And

instead of the promise of a lenient sentence to entice the suspects to confess, the introduction of a generous federal match rate incentivizes states to expand their programs.

I will first model the state's strategic decision of whether or not to participate in the Medicaid program and then consider the decision to expand the program in a subsequent year. To simplify things, I assume a federal system with just two states. Both states are the same size and the residents of each state have the similar preferences for the size of a state's health program for the poor. Absent any federal intervention I assume that both states would commit $10 million of state revenues to their programs. Under this budget, the poorest residents get $10 million in medical care and the general public get a collective benefit, measured in utility, that they value at $10 million. This allocation of resources is considered to be Pareto efficient because both the general public perceives a benefit at least equal to the cost. Beyond $10 million in spending, however, the general public perceives a diminishing return on the utility of their investment. The general public values the subsequent $10-million investment at $9 million in utility. A further $10 million has a utility of just $8 million. And so on, according to the simple step function defined in **Figure 1.4**.

Figure 1.4. Hypothetical utility function for a state's health care spending on the poor



While the poor will fare better with each subsequent investment into their health care needs and a large health care budget may lead to a more equitable allocation of resources it would not be Pareto

efficient to invest anything beyond the initial $10 million allocation. The cost of any additional investment exceeds the benefits that the general public would receive from the expenditure on health care. For example, the additional $10 million in health care could necessitate a reduction in certain services that the general public preferred or an introduction of new taxes that exceeded the value of the health care benefit.

Now assume the presence of a federal government. The federal government has different preferences with respect to health care spending and does not believe that a $10 million budget is sufficient. To incentivize states to spend more on health care the federal government decides to implement a program that matches what the state spends on health care, so long as the state agrees to maintain their earlier commitment of $10 million. Significantly, however, the residents of the individual states must still contribute toward the financing of the total federal share. Regardless of whether or not both states participate in the new federal program, the cost of the net federal share will be distributed uniformly across the two states. A state gets no utility from any health care spending in other states.

How do the states respond to this new federal-state program?

Figure 1.5 is a normal form representation of the strategic choices of **State A** and **State B** involving the decision of whether or not to participate in this new federal-state health care program. It resembles the prisoner's dilemma from **Figure 1.3**. In addition to presenting the net pay-offs of the different strategies, each quadrant in the matrix also includes the utility of the specified amount of health care spending (i.e. the value of the benefit given the diminishing marginal utility of spending, as defined in **Figure 1.5**) and the cost of the strategy for each state (i.e. sum of the cost for the state's own share and half of the net federal shares). The payoff for each state is the net utility of the health care benefit less the cost of the strategy. The following reflect the strategic decisions of **State A**:

- If **State B** does not participate in the federal-state program, then **State A** should participate. **State A** gets an additional $10 million in health care that has a marginal value of $9 million to

the public, and because both states finance the net federal-share, the indirect marginal cost to **State A** is an additional $5 billion to the state. Overall, **State A** receives a positive payoff that the state values at $4 million. The alternative for **State A** would be to likewise not participate in the federal-state program, in which case **State A** would get an inferior outcome valued at $0.

- If **State B** participates in the federal-state program, then **State A** should also participate. As above, **State A** gets an additional $10 million in health care that has a marginal value of $9 million to the public; however, because both states are now participating total federal spending is $20 million. With each state financing half of that amount, **State A** has an indirect marginal cost of $10 million. The total investment by **State A** is now $20 million. Compared to the marginal benefit valued at $19, the state has a net pay-off of -$1 million. This is preferable to the alternative strategy of not participating, in which case **State A** would get a net payoff of -$5 million.

Figure 1.5. Normal form representation of strategic choices of states choosing whether or not to participate in federal-state program. (Nash Equilibrium highlighted in grey.)

		State B	
		Non-Participation $10 million state program	**Participation** $10 million state share ⇨ $20 million budget
State A	**Non-Participation** $10 million state program	Utility of Health Care: (10, 10) Net Cost: (10, 10) Net Payoff: **(0, 0)**	Utility: (10, 19) Cost: (15, 15) Payoff: **(-5, +4)**
	Participation $10 million state share ⇨ $20 million budget	Utility: (20, 11) Cost: (15, 15) Payoff: **(+4, -5)**	Utility: (19, 19) Cost: (20, 20) Payoff: **(-1, -1)**

Given identical preferences and costs, **State B** will make the same strategic decision as **State A**, leading to the Nash equilibrium of both states participating in the federal-state program. Each state gets utility valued at $19 from the $20 million of health care spending. But each state's cost total $20 million,

for a negative net payoff. As was the case in the traditional example of the prisoners' dilemma in which both prisoners confessed both states are made worst off. However, given the participation of the other state, not participating in the federal-state program would lead to an even worst outcome.

Having participated in the program what will the states do in the next budgetary period? For this second period, I will assume that the two states will again independently decide if they should maintain their participation in the program and how much should they spend if they do so.

The states' decisions to maintain their participation are the same as above and so it is not rational for the states to stop participating. The states' policy choices thus become deciding upon how large of a budget to commit to the federal-state program. As provided for the previous example, **Figure 1.7** is a normal form representation of the strategic choices of **State A** and **State B** involving the choice of how large a budget to support. Both states will settle on a total budget of $30 million. Regardless, of the choice of the other state, neither state improves its utility by increasing its total budget beyond $30 million. The cost of increasing the state's budget from $30 million to $40 million would be another $7.5 million to the state (i.e. the sum of the state's $5 million state-share and one-half of the corresponding $5 million federal share); but this amount exceeds the marginal utility, valued at $7 million, that the state gets from the additional $10 million in health care spending.

Although the states' budgets do not spiral upwards in this simple example it is worth noting that compared to the original situation in which the states exclusively financed their own program with a limited $10 million budget the state is worse off in this new equilibrium, with a budget of $30 million budget and a negative payoff of -$3 million.

Figure 1.6. Normal form representation of strategic choices of states for determining size of budget. (Nash Equilibrium highlighted in grey.)

		State B		
		$10m state-share ⇨ $20m budget	$15m state-share ⇨ $30m budget	$20m state-share ⇨ $40m budget
State A	$10m state-share ⇨ $20m budget	Utility: (19, 19) Cost: (20, 20) Payoff: **(-1, -1)**	Utility: (19, 27) Cost: (22.5, 27.5) Payoff: **(-3.5, -0.5)**	Utility: (19, 34) Cost: (25, 35) Payoff: **(-6, -1)**
	$15m state-share ⇨ $30m budget	Utility: (27, 19) Cost: (27.5, 22) Payoff: **(-0.5, -3)**	Utility: (27, 27) Cost: (30, 30) Payoff: **(-3, -3)**	Utility: (27, 34) Cost: (32.5, 37.5) Payoff: **(-5.5, -3.5)**
	$20m state-share ⇨ $40m budget	Utility: (34, 19) Cost: (35, 25) Payoff: **(-1, -6)**	Utility: (34, 27) Cost: (37.5, 32.5) Payoff: **(-3.5, -5.5)**	Utility: (34, 34) Cost: (40, 40) Payoff: **(-6, -6)**

Of course, despite the inefficiency of the lower utilities the outcome is presumably assessed as preferable from the perspective of the federal government. As a result of the cost sharing mechanism the program now has a budget that is three times the size of what it would have been without the federal matching grants. Whether or not $30 million is sufficient to meet the needs of the poor is a political question, but the increased redistribution toward the poor is, presumably, more equitable and reflects a fairer allocation of resources than the original situation in which both states committed just $10 million.

This equilibrium is not very robust, however. Minor changes to the assumptions of the models will lead to significantly different results and the models stable Nash equilibrium splintering. Among the many potential permutations of the model's assumption, consider the potential impact of the three following changes on the states' strategic policymaking:

1. In the original examples the net federal cost was split evenly between the two states. If instead one state pays a greater proportion of the federal share, maybe because it is richer and its residents pay more federal income taxes, then the poor state will receive what amounts to a subsidy, paid for by the rich state. Assuming the states maintain the same preferences, then it is likely that the poor state will raise its own Medicaid budget while paying a lower share of the net

costs. The rich state in turn will pay a larger share of the costs and experience a lower pay off, holding all else constant. For example, if State A finances 75 percent of all federal spending then the poor state, State B, will raise its budget to $40 million and the rich state, State A, will reduce its budget to $20 million.[10]

2. In the original scenario the two states had the same preference for health care spending on the poor. If instead one state receives a higher marginal utility from this spending, maybe because this state has a large number of health professionals among the public, then this state may favor more spending relative to the other state. The federal share associated with this state's additional spending, however, will still be financed by both states and so the net payoff derived from this federal-state program will be affected—reducing the payoff for the state maintaining the lower marginal utility and increasing the payoff for the state with the higher marginal utility.[11]

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[10] **Figure F.1.1** represents this first alternative scenario with the assumption that **State A** is a rich state that must finance 75 percent of the federal share. This change will affect the net cost of the strategic decisions that in turn affects net payoffs. Both states maintain the same utility function defined by **Figure 1.4** and receive a 50 percent federal match. In this situation, the Nash Equilibrium sees **State A** supporting a budget of $20 million and **State B** supporting a budget of $40 million. Instead of the original payoffs of -$3 million each (given the states' $30 million budgets), in this new scenario, the richer **State A**, is significantly worst off with a payoff of -$13.5 million, while the poorer **State B** now has a positive payoff at $6.5 million.

Figure F.1.1 Normal form representation of strategic choices of states for determining size of budget given different state liabilities for federal share. Nash Equilibrium highlighted in grey.

		State B *(State B is liable for 25% of total federal spending)*			
		$10m state-share ⇨ $20m budget	$15m state-share ⇨ $30m budget	$20m state-share ⇨ $40m budget	$25m state-share ⇨ $50m budget
State A *(State A is liable for 75% of total federal spending)*	$10m state-share ⇨ $20m budget	Utility: (19, 19) Cost: (25, 15) Payoff: **(-6, +4)**	(19, 27) (28.75, 21.25) **(-3.5, +6.25)**	(19, 34) (32.5, 27.5) **(-13.5, +6.5)**	(19, 40) (36.25, 33.75) **(-17.25, +6.25)**
	$15m state-share ⇨ $30m budget	(27, 19) (33.75, 16.25) **(-6.75, +2.75)**	(27, 27) (37.5, 22.5) **(-10.5, +4.5)**	(27, 34) (41.25, 28.75) **(-14.25, +5.25)**	(27, 40) (45, 35) **(-18, +5)**

[11] **Figure F.1.2** represents the second alternative scenario under the assumption that **State A** derives a utility valued at $10 million for the initial $10 million in spending, with each subsequent $10 million allocation valued at $500,000 less than the previous allocation (instead of $1 million less as in the original examples); **State B** has the same utility function as defined above in **Figure 1.4**. Both states maintain the same cost sharing functions.

3. In the original examples there were only two states. If instead of just two states the model incorporates fifty states and each is state responsible for 1/50th of the total cost of the federal shares, then every state will likely favor a significantly larger budget. Regardless of what the other 49 states do so long as the marginal utility of the additional $10 million that a state puts towards its own health budget exceeds the marginal cost of the investment then the state will support the larger budget. Applying the original examples' utility function (see **Figure 1.4**) all fifty will settle on a $50 million budget.[12]

Maintaining the original cost functions, the Nash Equilibrium now has **State A** supporting a budget of $60 million for a net payoff of $2.5 million and **State B** has a budget of $20 million for a negative payoff of -$2.5 million.

Figure F.1.2 Normal form representation of strategic choices of states for determining size of budget given different utility functions for health care spending on the poor. Nash Equilibrium highlighted in grey

		State B *(State B has a lower marginal utility for health care spending)*		
		$10m state-share ⇨ $20m budget	$20m state-share ⇨ $40m budget	$30m state-share ⇨ $60m budget
State A *(State A has a higher marginal utility for health care spending)*	$10m state-share ⇨ $20m budget	Utility: (19.5, 19) Cost: (20, 20) Payoff: **(-0.5, -1)**	(19.5, 27) (25, 35) **(-5.5, -8)**	(19.5, 34) (30, 50) **(-11.5, -16)**
	$20m state-share ⇨ $40m budget	(37, 19) (35, 25) **(+2, -6)**	(37, 27) (40, 40) **(-3, -13)**	(37, 34) (45, 55) **(-8, -21)**
	$30m state-share ⇨ $60m budget	(52.5, 19) (50, 30) **(+2.5, -11)**	(52.5, 27) (55, 45) **(-3.5, -18)**	(52.5, 34) (60, 60) **(-7.5, -26)**
	$35m state-share ⇨ $70m budget	(59.5, 19) (57.5, 32.5) **(+2, -13.5)**	(59.5, 27) (62.5, 47.5) **(-3, -20.5)**	(59.5, 27) (67.5, 62.5) **(-8, -36.5)**

[12] With 50 players it is difficult to construct a normal form representation of the complete choice set of **State A** given all the possible permutations of choices by the 49 other states. **Figure F.1.3** represents the strategic choices available to **State A** and the 49 other states, assuming the 49 other states all make the same decision and the same utility function defined in **Figure 1.4**. Instead of **State A** facing a marginal cost of $7.5 million for every $10 million increase in its state's budget, the marginal cost is only $5.1 million (i.e. $5 million state share + 0.02 × $5 million federal share). Every state has the same marginal cost function and will make investments until the marginal cost exceeds the value of the benefit. For every state that point occurs at $50 million. With each state drawing down $25 million in federal funding, the total federal share will equal $1.250 billion (i.e. $25 million x 50 states). Therefore total spending by each state will be $50 million (i.e. $25 million state share + 0.02 × $1.250 billion contribution to federal share) and the net payoff in this Nash equilibrium will be -$10 million for each state.

Figure F.1.10 Normal form representation of strategic choices of states for determining size of budget given different state liabilities for federal share. Nash Equilibrium highlighted in grey.

49 "Other" States
(Collective Utility/Cost/Payoff of 49 "Other" States, <u>each</u> responsible for 1/50 of total federal spending)

Researchers and policymakers can use such game theoretic abstractions to forecast the potential implications of the FMAP funding formula and the states' preferences for health care spending on state and federal budgets—although formally modeling the impact of such refinements to the model is beyond the scope of this dissertation. With respect to this dissertation's current research agenda on the political development of the FMAP funding formula, it is sufficient to take from the above examples an appreciation for how federal cost sharing can incentivize state policymakers to support and sustain suboptimal outcomes.

		\$10m state-share ⇨ \$20m budget × 49 states	\$20m state-share ⇨ \$40m budget × 49 states	\$25m state-share ⇨ \$50m budget × 49 states	\$30m state-share ⇨ \$60m budget × 49 states
State A *(State A is liable for 1/50 of total federal spending)*	\$10m state-share ⇨ \$20m budget	Utility: (19, 931) Cost: (20, 980) Payoff: **(-1, -49)**	(19, 1666) (29.8, 1950.2) **(-10.8, -284.2)**	(19, 1960) (34.7, 2435.3) **(-13.5, -475.3)**	(19, 2205) (39.6, 2920.4) **(-20.6, -715.4)**
	\$20m state-share ⇨ \$40m budget	(34, 931) (30.2, 989.8) **(+3.8, -58.8)**	(34, 1666) (40, 1960) **(-6, -294)**	(34, 1960) (44.9, 2445.1) **(-10.9, -485.1)**	(34, 2205) (49.8, 2930.2) **(-15.8, -725.2)**
	\$25 state-share ⇨ \$50m budget	(40, 931) (35.3, 994.7) **(+4.7, -63.7)**	(40, 1666) (45.1, 1964.9) **(-5.1, -298.9)**	(40, 1960) (50, 2450) **(-10, -490)**	(40, 2205) (54.9, 2935.1) **(-14.9, -730.1)**
	\$30m state-share ⇨ \$60m budget	(45, 931) (40.4, 999.6) **(+4.6, -68.6)**	(45, 1666) (50.2, 1969.8) **(-5.2, -303.8)**	(45, 1960) (55.1, 2454.9) **(-10.1, -494.9)**	(45, 2205) (60, 2940) **(-15, -735)**

SECTION II: THE LEGISLATIVE HISTORY OF FEDERAL-STATE COST SHARING FOR MEDICAL VENDOR PAYMENTS

The Social Security Act of 1935 established the national Old Age and Survivors Insurance, or "Social Security." The Act also established three federal-state public assistance programs—Old Age Assistance, Aid to the Blind, and Aid to Dependent Children. Aid to the Totally and Permanently Disabled was added in 1958. Medicare and Medicaid, both, were built upon this shared foundation and further exemplify—like Social Security, on the one hand, and, Old Age Assistance, on the other—the complementarity of the nation's universal federally-administered social insurance programs and disparate state-administered means-tested welfare programs. However, whereas Medicare, like Social Security, was and remains heralded by Americans, both elected or otherwise, Medicaid was largely ignored by the public in 1965 and has generally befuddled voters and state and federal officials alike in the proceeding decades.

While this section accepts that a healthy ambivalence for how the nation insured its unhealthy poor was a necessary condition for the development of Medicaid, such benign neglect does not sufficiently explain Medicaid's resilience. Relatedly, theories of path dependencies diminish the agency of those state and federal policymakers who over the past six decades have annually approved expanding medical assistance budgets. It is unsatisfactory historicism and reductivism to rationalize Medicaid's current size and

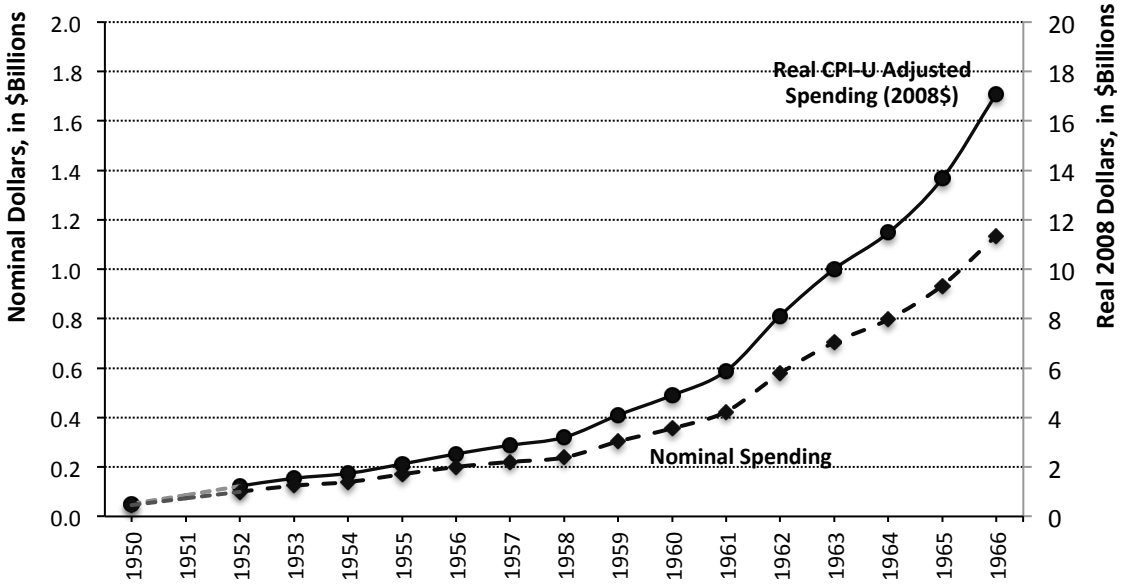
scope as wholly the unintended consequence of what one could charitably characterize as a distracted policymaking process.

This section takes the perspective that Medicaid was not a policy postscript to Medicare; that Medicaid's policy salience should not be gauged solely by its political salience during the debates of 1965 and thereafter. As David Smith and Judith Moore argue in *Medicaid Politics and Policy, 1965-2007* (2008), a comprehensive history of the national politics of Medicaid policymaking, "Medicaid was anything but a casual afterthought; it was the culmination of a lengthy development and of the strategic and tactical calculations of Wilbur Cohen and Wilbur Mills" (Smith and Moore 2008: 81). Smith and Moore rightly reject the characterization that Medicaid was "a casual and belated inclusion" into the legislation for Medicare. Instead they portray Medicaid "as the culmination and ratification of a project begun almost twenty years earlier: to create a health benefit for the poor by incremental expansion, using the Social Security Act as a legislative vehicle" (Ibid. 21). Like Smith and Moore, Robert Stevens and Rosemary Stevens' *Welfare Medicine in America: A Case Study of Medicaid* (2003 [1974]) and Laura Katz Olson's *The Politics of Medicaid* (2010), too, offer comprehensive histories of Medicaid that elevate its salience relative to its undistinguished popular perceptions.

The next four chapters explore Medicaid's institutional heritage and its subsequent five decades of political development to better understand Medicaid's fiscal and policy importance. Using the perspective of federal-state fiscal politics, this section outlines how a precedent for the public provision of welfare medicine was established early in the American welfare state and how that precedent was maintained (and expanded upon) even as the nation's notion of the welfare state and health insurance was being challenged by both the Left and Right.

In order to establish a baseline of federal and state commitments to medical assistance for the poor, **Figure II.1** charts public spending on medical vendor payments in the 15 years prior to enactment of Medicaid in 1965. This was a period of nascent reforms to how the nation financed means-tested medical vendor payments. While the total fiscal commitments made by Congress and the state capitals were modest, the institutional structures that were put in place during this time have remained largely unchanged.

Figure II.1. Total Medical Vendor Payments, Nominal and Real (2008 dollars) Spending, FY1950-1969

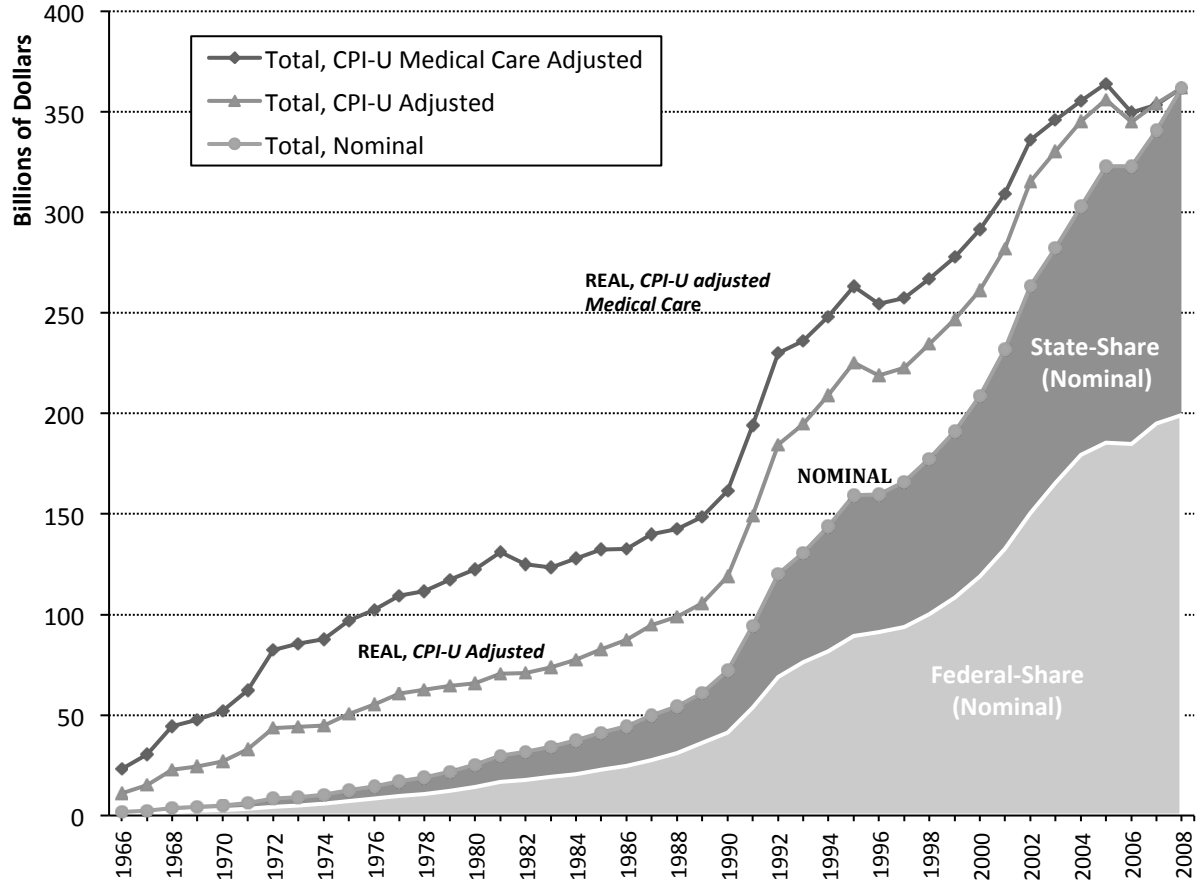


Sources: FY1950-1960, 1965-66: Merriam, IC. 1967; FY1961-64: Merriam, IC. 1965.

Figure II.2 pulls back and looks at historical spending between 1965 through 2010, overlaying the total inflation-adjusted annual spending on Medicaid (and CHIP; and the various means-tested medical assistance programs before 1965) with the average percent of a state's overall budget that is being committed to the program. This dissertation considers the steep trajectory in costs that these two figures present. Does a financial arrangement used to distribute less than $20 billion in total spending in 1965

remain the appropriate mechanism for distributing over $350 billion in 2008 (in constant 2008-adjusted dollars)?

Figure II.2 Total Medicaid/CHIP Payments (inc. Administration/DSH Payments), Nominal and Real (2008 dollars) Spending, FY 1966-2008.



Source: 1966-1979: Committee on Ways and Means, House. 1985. "Medicare, Health Care Expenditures, and the Elderly."(March 15) 99th Congress, 1st Session Washington, DC: US Government Printing Office (Committee Report No. WMCP 99-6); 1980-2008 author generated from data requested from Centers for Medicare & Medicaid Services.

By approaching Medicaid's early implementation and subsequent reforms from the perspective of its federal-state fiscal relationship, the history recounted over the following pages diverges from existing narratives of Medicaid that explore the policymaking process and national politics of health care more generally. Instead, this section takes as its premise that to understand Medicaid's continued resiliency and incremental expansions it is necessary to study the development of Medicaid's cost sharing arrangement that

undergirds the fiscal relationship between the federal government, and states. James Blumstein and Frank Sloan credit Medicaid's generous, open-ended cost sharing with having a "political lock-in" effect on policy because "the matching formula that makes program enhancements so appealing also makes cutbacks very unappealing" (2000: 133).

From the viewpoint of both the legislative successes and failures, the development of the fiscal underpinnings of the nation and states' medical vendor payments appears to exemplify the path dependent policy incrementalism articulated by Jacob Hacker and Paul Pierson. However, in contrast to reductive institutionalism that minimizes political agency, an implicit premise underlying the following narrative is that the high level of spending on welfare medicine and tenacity of the Medicaid funding formula can be explained by the rational behavior of policymakers responding to external influences. The generous federal match provides states' with a relatively inexpensive source of revenues to meet a social commitment to their poorest residents and placate the political demands of powerful interest groups and sympathetic constituencies, such as doctors, hospitals, the elderly and disabled. As such, the common parlance of path "dependency" unduly marginalizes political agency and the intentionality of the reforms legislated by Congress and implemented by the states.

Chapter 2 and **Chapter 3** are prequels to the quantitative study that follows in the next section. **Chapter 2** traces Medicaid's institutional heritage and the legislative antecedents to Medicaid's matching formula back to the enactment of the Social Security Amendments of 1950. The foundational narrative continues with a review of the three subsequent pieces of legislation passed between 1955 and 1960 that amended the Social Security Act and impacted the provision of medical assistance to the poor. The 1960 amendments introduced the Kerr-Mills program—the optional federal-state program of medical assistance for the elderly poor, that, itself, represented an incremental expansion of those federal policies introduced over the previous decade. Yet, even after fifteen years of steady annual expansions the total federal and state

commitment to means-tested medical assistance remained less than a paltry $1 billion by 1965 ($6.76 billion in 2008-adjusted dollars), with the federal government's commitment accounting for considerably less than a third of this commitment to the nation's poor. At the state level, the desperate programs of medical assistance had required no more than a few percentage points of any state's revenue.

Chapter 3 opens with the passage of the Social Security Act of 1965 and the enactment of Medicaid under Title XIX of the Act. Medicaid significantly broadened eligibility requirements of Kerr-Mills and mandated new standards of care for welfare medicine. In contrast to the contentious debate surrounding Medicare and its promise of universal coverage for the aged, there existed a general consensus in Washington that the medical safety net needed further expanding. Most policymakers perceived Medicaid's funding and administrative framework as a reasonable and incremental reform of the status quo arrangement. In terms of its ultimate costs, however, Medicaid would quickly prove to be anything but incremental as Medicaid eclipsed all budgetary estimates. The inflationary growth can be attributed, in part, to a pervasive under-appreciation—albeit not an entirely justified ignorance— by policymakers of the poor's previously unmet need for welfare medicine as well as to the state's enthusiasm for leveraging federal dollars.

The chapter therefore proceeds from the enactment of Medicaid to a consideration of the almost immediate attempts by Congress in 1967 and 1968 to retrench Medicaid and control its unanticipated costs. Subsequently examined is a report prepared by the McNerney Task Force of 1969 that President Richard Nixon commissioned to address Medicaid's almost immediate fiscal crisis. Despite resolving Medicaid's cost crisis being the impetus for the report, the Task Force reported on how Medicaid's present financing arrangements was not adequate and concluded that without a considerable improvement in financing and delivery capabilities the promise of Medicaid to assure adequate healthcare to the nation's poor and near poor would not be met. While further recognizing that in an economy of scarcity society needed to make

decisions on the proper allocation of resources for good, the Task Force tried to shame the government into action by characterizing the "sizable unmet need for health service as a disgrace"; one that "cannot be tolerated in an affluent society … because human compassion insists that essential individual health needs shall be met" (*Report of the Task Force* 1970). However, "the Task Force had neither the resources nor the time … to examine closely the full dimensions of the problem" (*Social Security Bulletin* 1970: 30). While such a thorough examination was needed, it would not come during the 1970s.

Chapter 4 and **Chapter 5** look at the continued growth in Medicaid budgets since 1980 and examine how the states' increasing financial commitments ultimately compelled a reform of the traditional Medicaid funding formula. The 30-year period between 1981 and 2010 is also the time frame that will be given greater attention from a quantitative perspective in **Section III**. This extended time period saw several major efforts by the various Republican and Democrat administrations and Congresses to reform Medicaid, particularly its cost sharing formula. **Chapter 4** will explore several of those attempts that failed. The chapter begins with a legislative history of the Omnibus Budget Reconciliation Act of 1981 involving President Reagan's effort to convert the open-ended entitlement structure of Medicaid into a capitated block grant; followed by President Reagan's unexpected response to his failure to do so by proposing a federal takeover of Medicaid in 1982. Stepping out of chronological order, the chapter provides a brief review of the rationale behind, and the ultimate failure of, the subsequent attempts by congressional Republicans and President George W. Bush to block grant Medicaid. The chapter then considers more modest amendments to Medicaid's cost sharing arrangement, including proposals by Senator Patrick Moynihan's (D-N.Y.) to reform the inequities of what he criticized as an arbitrary funding calculus and a report from the CBO released in 1982 that similarly suggested alternatives to the FMAP funding formula. None of these efforts at reform would succeed and costs would continue to escalate, particularly after

Congress enacted a series of federal mandates in the second-half of the 1980s that ignited an explosion in the number of Medicaid enrollees.

Chapter 5 proceeds into the 1990s and the federal government's hesitant acceptance of the fact that Medicaid's original cost sharing model was insufficient to meet the states' demand for Medicaid services and the subsequent costs thereof. Exasperated by the rising price of health care delivery and rising enrollments after a decade of stagnation, the status quo for Medicaid financing had, again, become unsustainable. Whereas past reform efforts emphasized the need to control federal spending, the reforms examined in this chapter have all helped relieve state governments of some of the fiscal stress imposed by Medicaid.

By the mid-1990s, the proportion of state budgets appropriated to Medicaid often exceeded 25 percent, up from just a few percentage points spent on medical vendor payments in 1965 and still more than double what the average had been the previous decade. Medicaid had eclipsed education as the costliest item in several states' budget. Although the unsustainability of the increasing taxpayer burden of Medicaid had been a recurring theme throughout Medicaid's history, the real inability of the states to continue to meet Medicaid's increasing fiscal burden compelled reform.

The states would respond first to the fiscal strain by learning to creatively leverage Disproportionate Share Hospital payments and, later, Upper Payment Limit appropriations to augment their budgets. By offsetting their DSH and UPL outlays with provider-specific taxes on hospitals or intragovernmental transfers on local governments (who often help finance hospitals) the states could collude with providers to recoup their own-source expenditures and thereby effectively raise the federal share going toward their Medicaid operations. While Congress would quickly respond by redressing what they perceived as an abuse of these so-called Medicaid maximization schemes, by limiting and not

eliminating these practices Congress effectively acknowledged the incapacity of the states to meet the increasing cost of their Medicaid commitments and providing coverage to the uninsured.

Following the states' own initiatives, the federal government's own reforms would reflect a rebalancing of the shared responsibilities for financing Medicaid. This rebalancing was demonstrated by: the bipartisan enactment of the State Children's Health Insurance Program ("CHIP") in 1997 (and its reauthorization in 2009), a supplemental block grant that incorporated a more generous federal matching rates; the temporary increases to the state's federal shares in response to economic downturns in 2003 and 2005, and; the enactment of the Patient Protection and Affordable Care Act of 2010 and the Medicaid expansion included therein. These policies all represent an understanding by federal and state policymakers that Medicaid's cost sharing arrangement had become inadequate to meet the broadening societal need for, and public cost of, welfare medicine.

Taken together the distinct legislative moments described in these four chapters, whether successful or, more often than not, unsuccessful, are particularly significant in understanding the institutional and political development of the federal government's financial participation in, and the states' commitments to, Medicaid.

Chapter 2.

Early Vendor Payments and Welfare Medicine, 1950-1960

The provision of federal support for means-tested medical assistance for the poor dates back to at least the Sheppard-Towner Maternity and Infancy Act of 1921 (P.L. 67-97)[13] and Title V of the Social Security Act of 1935 (P.L. 74-271) that made available matching grants to the states for purposes of enhancing maternal and child health services.[14] Before proceeding to those specific legislative moments in which the federal government expanded the health care safety net through its grants-in-aid programs to the states, it is worthwhile to establish a foundation with respect to the federal government's more general fiscal support for the states' welfare programs.

Title V was of course part of a broader social program that set the institutional and financial framework for both Medicare and Medicaid. In general, the Social Security Act of 1935 exemplified the administration and Congress' increasing New Deal activism and confidence of in the use of federal power to enact national social policies. Specifically, Titles I, IV and X of the Social Security Act of 1935, establishing Old Age Assistance ("OAA"), Aid to Dependent Children ("ADC"), and Aid to the Blind ("AB"), were three new means-tested federal-state programs that provided direct assistance to the poor. These programs are

[13] The Shepperd-Towner program ceased in 1929 after Congress failed to renew its funding in 1927 and allowed the program sunset; although 19 states continued the program without federal funding (Lemons 1969)

[14] More generally, in 1798, President John Adams signed into law, "An Act for the Relief of Sick and Disabled Seaman," mandated health care insurance for certain individuals. This extraordinarily progressive law levied a mandatory tax of 20 cents per month, equivalent to about 1 percent of wages, on all merchant seamen, that subsidized the cost of their publicly financed health services and creation of marine hospitals (5 Cong. Ch. 77, July 16, 1798, 1 Stat. 605). Comparatively, the total employer- and employee-paid tax for Medicare was set at only 0.70 percent of wages in 1966; it has been incrementally increased over the years, reaching its current level of 1.45 in 1986.

the institutional precursors to Medicaid. In contrast to these welfare titles, Title II of the Act enacted Old-Age and Survivors Insurance—what is colloquially known as Social Security—as a strictly federal social program that would become the vehicle for implementing Medicare. OAA, ADC and AB, like Medicaid, would be are paid out of general revenues; Social Security, like Medicare, would have its own dedicated revenue source that was, in part, financed by a contributive tax on all workers. Whereas Social Security's funding mechanism lends the supports the perception that benefits are earned, the historical perception of welfare payments has been that they are unearned.

For the aged indigent, OAA initially provided a federal match equal to one-half of a state's cash payments up to a maximum of $30 per individual aged 65 or older, per month. For dependent children, ADC provided a federal match equal to one-third of a state's cash payments made on behalf of children up to a specified maximum ($18 for the first child and $12 for each additional child, per month); under the 1939 amendments, the federal match was raised to 50 percent (P.L. 76-379). Throughout the forties and fifties both the maximum amount eligible under the federal match and the percentage that was reimbursed by the federal government was increased several times for both programs.

These federal-state welfare programs represented an early, if lenient, form of cooperative federalism that would become a hallmark of Medicaid. Nicole Huberfeld describes how the Social Security Act "adopted and codified states' categories of deserving poor into federal law," thereby federalizing a bias toward limiting public assistance to the elderly, children, blind, and those otherwise disabled (2011: 441). However, while the Social Security Act provided federal funding to support specific state-based welfare programs and established broad parameters for benefits and eligibility, the states were allowed significant discretion and were not asked to alter their public assistance mechanisms to receive that funding. "In other words," Huberfeld explains. "The states were free to implement federal funding as they saw fit, which could be described loosely as a system of federal-state cooperation but was really a set of federal grants to the

states to continue providing assistance to the deserving poor with no conditions attached to the federal spending" (2011: 442).

Noteworthy with respect to the historical development of Medicaid's fiscal underpinning, in the 1940s, the federal government moved away from a fixed federal matching rate to a variable rate that better tied the amount of federal assistance given to the states to the states' ability to pay. With enactment of the Social Security Act Amendments of 1946 (P.L. 79-719), the federal government transitioned to a staggered-grants-in-aid, replacing the flat fifty-percent match (for assistance up to a specified maximum). The Federal government would now reimburse states for a percentage of payments up to a certain level and then at a lower percentage for payments that exceeded the initial threshold and fell below a second level. All payments above the second threshold would be paid entirely by the State. This staggered funding mechanism effectively boosted federal support for those states with lower welfare payments. It also meant that those states that had more generous welfare programs would be required to pay a greater proportion of their programs' costs that exceeded a certain level directly from their own fiscal resources.

However, the staggered grants-in-aid approach remained based on a state's willingness to pay, not necessarily the state's ability to pay. As one scholar rightly observed, "the focus of this change in 1946 is to further support States which offer lower benefit payments as opposed to offering additional assistance to States with lower fiscal capacities" (Thomas 1995).

The chairman of the Social Security Board, Arthur Altmeyer, supported by some members of Congress, had proposed an alternative matching formula that compared to the staggered grants more explicitly provided additional assistance to those states with lower fiscal capacity. Introduced earlier, during the congressional debates over the 1939 amendments to the Social Security Act, the Senate Committee on Relief and Unemployment recommended that the federal contribution for the states' welfare program

should be at a higher rate for poorer states that have less capacity to finance their program. The report of the Committee recommended,

> The contribution of the United States for public assistance for the aged, the blind, and dependent children be 50 percent of the amount paid, but that in those States where the average per capita income is less than the average per capita income of the United States, the Federal contribution be increased in proportion to such differences, and that a provision of the grant should be the guarantee of certain minimum payments (Peterson and Rom, 1990: 101; quoting *Congressional Record*, June 6, 1939, p. 6684)

While not immediately implemented for ADC or OAA, this variable federal matching formula was also enacted in 1946, to subsidize the states' school lunch programs (P.L. 79-396). The variable match was expanded to hospital construction in 1949, with implementation of the Hospital Survey and Construction Act of 1946 (P.L. 79-725).[15] The subtle nuance between a states willingness and ability to pay is given greater attention later in this chapter when the Social Security Amendments of 1958 expanded the applicability of the variable matching rate to the above federal-state welfare programs.

In reviewing the four major amendments to the Social Security Act that passed between 1950 and 1960, inclusive, this chapter describes how the federal government's approach toward medical assistance would closely follow the approach taken by Washington to subsidize and incentivize the states to commit their resources toward their cash assistance welfare programs.

The Social Security Amendments of 1950 (P.L. 81-734)

[15] More commonly referred to as the Hill-Burton Act, this program offered grants to states to subsidize hospital construction or maintenance (expanded to include nursing homes in 1954), provided that the institution delivered a "reasonable volume of free and reduced cost care" to "individuals unable to pay" and to make their services "available to all" (P.L. 79-725 at § 622).

Before the enactment of the Social Security Amendments of 1950, federal regulations for the nation's "categorically needy" assistance programs—OAA, Aid to the Blind ("AB") and ADC—required all welfare payments to be made directly to recipient. Federal law restricted any federal match dollars from being used to subsidize third party payments to doctors or hospitals. If a state welfare agency wished to make such in-kind vendor payments to a doctor or hospital on behalf of the poor, the payments had to be paid for exclusively with state and local general assistance funds.

This prohibition against federal funds being used for in-kind assistance was intended to empower welfare recipients and avoid the worst abuses of local poor houses; however, the policy had the unintended consequence of increasing a state's relative costs for providing medical care to their poor residents. Given the cost sharing incentive of the federal match to provide cash payment and without any federal subsidies to support their medical charity, the states provided only meager levels of direct medical assistance, if they provided any at all.

According to the report of the 1948 Advisory Commission, this prohibition against certain kinds of federal welfare assistance had the greatest impact on poor states with limited state tax revenues. To maximize the multiplicative effect of federal participation the states would direct their own limited resources to those services eligible for federal cost sharing. A state could augment its welfare budget more than once over if it distributed the funds as cash assistance to the recipients of one of the three federal-state categorically needy programs. The same was not true if those limited revenues were spent on health care.

"Some states apply virtually all the State and local funds available for public assistance to the specific programs for which Federal reimbursement is available, leaving little or no money for so-called general assistance," explained the Commission. "State funds are thus concentrated on programs which have Federal grants-in-aid" (Advisory Commission 1948: 100).

While, certainly, some states may have budgeted for medical care in the amount of cash allotments provided to the categorically needy, this marginal assistance was difficult to monitor and fell far short of adequately meeting the medical needs of the welfare population. Indeed, despite recognition by the Bureau of Public Assistance that sickness and disability were the "primary causes of the dependency of persons receiving public assistance" and that "at least a majority of the persons on general assistance rolls are suffering from acute or chronic illness or handicap," federal administrators suspected that "when a recipient's income is seriously inadequate, it is probable that medical needs, even though budgeted as requirements, often go unmet because of the more urgent need for food, housing, and clothing" (White 1952).

Similarly, the Advisory Commission on Intergovernmental Relations, in a later appraisal of the political legacy welfare medicine before Medicaid and Medicare, reasoned, "With full independence in use of their money payments, many recipients neglected medical care, often because States set the overall money payment level so low as to be insufficient for basic food and shelter" (Advisory Commission on Intergovernmental Relations, 1968). Whether or not the cash assistance was adequate, a general implication of the reports was that the states needed a degree of paternalistic flexibility in defining their welfare policies if they wanted to ensure the poor received adequate medical care.

Throughout the fifties, researchers in the Social Security Administration provided Congress with regular reports, either through testimony or through its in-house publication, the *Social Security Bulletin*, on the pressing health-related needs of the poor and current levels of expenditures on medical assistance at the state and federal level.[i] For example, in a report published in the June 1950 edition of the *Bulletin,* just months before Congress finished debating the Social Security Amendments of 1950, a government researcher prefaced his data on means-tested assistance for health care by noting that, "the Federal Government does not share in making payments to vendors." He estimated that medical vendor payments

paid exclusively by state and local assistance agencies totaled as much as $85 million for calendar year 1949 ($769 million in 2008 dollars). While the estimations were imprecise due to absence of any reporting requirements, the researcher further calculated that total assistance for medical care, including money payments paid to welfare recipients and subsequently used for medical care, amounted to a total $125 million ($1.1 billion in 2008 dollars; White 1950: 3). In all, two-thirds of all medical assistance provided by state and local welfare agencies was ineligible for any form of federal match due to the fact that reimbursements were paid directly to the provider.[16]

Further, with total public assistance approximating $1.95 billion in 1949 ($17.6 billion in 2008 dollars), medical payments, at $125 million or approximately 6 percent of the states' total welfare budgets, were only a marginal priority for the states; although, with as many as thirteen states having little to no medical payments, the proportion of welfare budgets directed to the medical care of the poor was higher in some states. For example, the state of Washington, in spending about 11 percent of the total assistance dollars on medical care was the most profligate in 1949. Unique among the states, the local welfare agencies in Washington contributed $2.50 per month for each individual on their welfare rolls to county medical services bureaus that then used these collections to make prepayments on healthcare-related charges incurred by welfare recipients. Across the state, net expenditures averaged $7.33 per month for each recipient on old age assistance and nearly $15 per family with dependent children. Unlike the cash assistance provided to these same welfare recipients, none of these health-related expenditures were eligible for federal cost sharing (White 1950).

[16] Another study by the same government researcher, this time of 20 states over a six-month period in 1946, corroborated his earlier article to argue that while many state and local governments had already institutionalized the provision of health services to the poor, federal participation was minimal. Importantly, this later study suggested that when states were not subject to federal restrictions on how assistance could be delivered to the poor (because no additional Federal participation could be obtained by including amounts in the money payments to welfare recipients), state and local governments favored making vendor payments directly to health care providers (White 1952).

Regardless of the federal prohibition against third party welfare payments, the government researcher noted, "federal maximums [for public assistance] are so low that money for medical services can seldom be included within the maximums [eligible for federal participation]" (White 1950: 5). In 1949, the federal government limited federal participation to a maximum of $30 of the first $50 paid in assistance to any individual each month. Any additional dollars above $50 that was paid was to an individual would have needed to be financed entirely with state and local tax revenues, whether the assistance was classified as general assistance or associated with one of the special federal-state assistance categories.

Again using the state of Washington as an example, the average money payment for an old age assistance recipient, at $68.26 per month in 1949, already far exceeded the maximum amount eligible for a federal match (Statistical Abstract 1950). Thus, the federal government would have reimbursed Washington the maximum $30, with Washington using its own state and/or local revenues to finance both the remaining $38.26 in cash assistance and the full amount of the $7.33 in vendor payments paid toward the medical care of OAA recipients. Given the strict capitation on the amount of federal assistance available to the states, it made little difference from a state's budgetary perspective if medical charges were paid directly with vendor payments to doctors and hospitals or indirectly via money payments to unhealthy welfare recipients. In neither case would the federal government have subsidized the states' budgetary commitments to the social welfare of their poorest residents.

The Social Security Amendments of 1950 (P.L. 81-734) was the first of several laws that incrementally increased the federal government's explicit role in financing (and administrating) medical care for the poor. Significantly, states could now use federal funds to directly reimburse medical vendors, albeit still within the strict fiscal limitations on the amount of federal revenues that would be distributed per welfare recipient.

The public assistance components of the 1950 law played "strictly a supplementary and secondary role" to the legislative change to the old age and survivors insurance (OASI) program that expanded eligibility to an additional 10 million workers and raised benefits by about 80 percent (Sidor 2010: 17). However, the new categorical grant-in-aid program for the disabled and the allowances for medical vendor payments were "necessary preludes"—to adopt Martha Derthick's observation of the relationship between disability insurance and Medicare (1979: 319)—to the substantial health reforms that would follow over the decade, culminating with Medicaid's passage in 1965.

While the final law did not include the Truman administration's preference for a comprehensive contributory disability insurance program modeled after OASI—the amendment having failed to be endorsed by the Senate Finance Committee and subsequently rejected by a voice vote on the Senate floor on fears that it was a harbinger of a more comprehensive health insurance agendas—the bill amended the welfare provisions of the Social Security Act to include a new state administered categorical grant-in-aid program of means-tested assistance to the "permanently and totally disabled." Congress made federal participation available to approved plans on the same basis as old age assistance and aid to the blind.

Given the expectation that the poor and disabled would have considerable unmet health care needs, the inclusion of this subpopulation precipitated a more general change to how the federal government approached the payment of medical care.

To that end, the 1950 amendments permitted states to use federal matching funds to directly finance medical vendor payments made to doctors and hospitals on behalf of certain welfare recipient. The federal government would subsidize these vendor payments on the same basis as it did money payments paid directly to the welfare payments. State participation was optional and eligibility remained tied to the states' definitions of categorically needy as used for its categorical cash assistance programs (the federal

government would not subsidize the vendor payments for recipients who only received state or local general assistance).

Federal participation with respect to vendor payments was limited, however, to the extent that the combined total of the cash payments *and* medical vendor payments to hospitals, doctors and other suppliers of medical services did not exceed the maximums on individual payments specified in the federal Act. In 1950 that matching formula remained set at three-fourths of the first $20 of the state's average monthly payment and one-half the remainder, up to an individual maximum of $50 per month (for a maximum federal contribution of $30 per month per individual); less for needy children. (The federal government separately compensated the states for one-half of its administrative costs for implementing and administering the system of vendor payment.)

For states with cash assistance payments already at $50, the state and local government budgets would have little incentive to alter their payment schedule. As cited above, a hard ` remained: "federal maximums are so low that money for medical services can seldom be included within the maximums" (White 1950).

Both chambers overwhelming passed the law—the conference report was passed 374 (140-R, 234-D) to 1 (1-R) in the House and by voice vote in the Senate. The law authorized an appropriation of $50 million ($413 million in constant 2008 dollars) for medical vendor payments during its first fiscal year of operation; the 1948 Advisory Council having earlier estimated that the annual cost of the reform to the federal government would range from $56 million to $89 million. President Truman signed H.R. 6000 on August 28, 1950.

Although the disability compromise received some press attention, no major news outlet made any specific mention of the medical vendor payments initiated with the law. The latter was also absent—except

in the most cursory and indirect nod—from President Truman's signing statement. Nonetheless, that the health-related provisions of the Social Security Amendments of 1950 were secondary does not diminish their incremental import to subsequent reforms.

In fiscal year 1951, 38 states reported having made medical vendor payments from general assistance funds; but only 15 states availed themselves of the opportunity to obtain Federal funds through any of the now four federally subsidized programs, including the newly passed aid to permanently and totally disabled (Social Security Bulletin 1952: 13). Further, an analysis by the Bureau of Public Assistance of the early impact of the 1950 amendment emphasized the minimal financial assistance provided by the federal government's new allowance for vendor payments. The Bureau estimated that less than a quarter of total vendor payments were even eligible for any federal cost sharing due to maximum on allowed federal participation. Of the total vendor payments paid by state and local governments, the federal government reimbursed just 13.2 percent (Norman 1952, based on June 1952 data). The Bureau approximated the cost of total federal participation at just $10 million for fiscal year 1952 ($80.2 million in 2008-adjusted dollars; Norman 1952: 9). Well below budgetary projections.

Between 1952 and 1960 medical vendor payments increased dramatically. However, given the low base at which they started, total commitments remained, in absolute terms, overall insufficient (if not insignificant from the perspective of state and local outlays) to meet the need among the poor for medical attention.

Table 2.1 presents data published annually in the *Social Security Bulletin* between 1953 and 1962 on the fiscal year expenditures on state-level medical vendor payments (inclusive of federal cost sharing) per resident for the four categorically needy programs as well as for state and local general assistance. A clear trend from the data is that an increasing share of any new state spending on medical care went to the

categorical assistance programs eligible for federal cost sharing and not state or local spending on general assistance that was not eligible for federal cost sharing.

A similar pattern will be seen in most states with Medicaid and CHIP spending: at least through implementation of the Affordable Care Act's Medicaid expansion in 2014, almost all means-tested medical assistance is directed exclusively to children, pregnant women, older parents, and, to a lesser extent, parents. Adults, however poor, are typically ineligible for assistance.

Table 2.1. State Spending (including Federal Grants-in-Aid) on Medical Care Vendor Payments, Fiscal Years 1952-1962

	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962
All State-Level Assistance Programs (includes General Assistance and Categorical Assistance* Programs)											
Total Spending, $millions	123	154	174	212	253	288	320	410	490	589	812
Average Spending per Capita, $	0.78	0.97	1.09	1.30	1.51	1.69	1.84	2.32	2.71	3.20	4.32
Total Spending, in Constant 2008 Dollars, $millions	999	1,245	1,393	1,703	2,003	2,207	2,384	3,033	3,564	4,241	5,792
# with No Vendor Payments	-	12	12	13	12	12	9	7	7	4	1
# with Vendor Payments	-	41	41	40	41	41	44	46	47	50	53
Vendor Payments per Inhabitant, # of states:											
less than $0.50	-	-	14	13	13	12	8	9	6	6	4
$0.50-0.99	-	-	5	5	4	5	7	4	8	7	4
$1.00-1.49	-	-	6	6	4	1	2	5	4	3	4
$1.50-1.99	-	-	7	6	8	5	4	2	1	1	6
$2.00 or more	-	-	9	10	12	18	23	26	28	33	34
Categorical Assistance Programs with Federal Cost Sharing*											
Per Capita Spending	-	-	0.75	0.90	1.08	1.27	1.37	1.78	2.16	2.59	3.78
# with No Vendor Payments	34	29	27	29	27	23	17	12	10	7	3
# with Vendor Payments	19	24	26	24	26	30	36	41	44	47	51
*Includes: Old Age Assistance, Aid to Blind, Aid to Dependent Children, Aid to Totally and Permanently Disabled											
General Assistance Programs											
Per Capita Spending	-	-	0.34	0.40	0.43	0.43	0.48	0.54	0.55	0.61	0.53
# with No Vendor Payments	14	13	13	14	13	14	15	16	15	14	14
# with Vendor Payments	39	39	40	39	40	39	38	37	39	40	40

Source: "Assistance Expenditures per Inhabitant, 19xx-19xy" in *Social Security Bulletin*, various years (1953-63).

The Social Security Amendments of 1956 (P.L. 84-880)

The next piece of legislation that was significant from the perspective of the federal financing of welfare medicine was the Social Security Amendments of 1956 (for summary see, Shottland 1967). This law differentiated federal grants-in-aid for medical care from cash assistance by enacting a separate matching rate for the former.

Significantly, under the 1956 amendment, federal financial participation with respect to vendor payments was no longer related to expenditures associated with an individual, but was changed to an average expenditure basis calculated across all recipients for each welfare program. Formerly any amounts paid in excess of the specified individual maximums were excluded from federal subsidization. Now, however, with respect to vendor payments at least, Congress would no longer limit federal appropriations according to a maximum payment level per individual recipient. Rather the federal government would provide the states with a federal match equivalent to one-half the state's costs, up to an *average* net expenditure of $6 a month per adult and $3 a month per child. (For cash assistance, the individual maximum was retained, but the amount eligible for federal cost sharing was raised to $60 for an adult, having been increased to $55 in 1952.)

As with the original 1950 legislation, the states could choose whether or not to offer vendor payments for all, any, or none of the four categorically eligible groups.

The provision represented the delayed enactment of a recommendation made eight years earlier by the 1948 Advisory Commission (albeit unadjusted for the intervening years of inflation). This earlier report had argued:

> It would be very difficult to meet medical needs with a ceiling imposed on individual payments. When medical bills are incurred, they are often large, particularly when the

> recipient receives hospital or nursing-home care. We recommend, however, the control of federal expenditures by limiting Federal contributions for medical care to one-half the amounts which average not more than $6 per month per person receiving old-age assistance and aid to the blind, and not more than $3 per month per person receiving aid to dependent children. (1948: 114)

Noting the unique nature of the health care spending as well as the limited fiscal capacities of poor states the Senate Committee on Finance, in their report on the proposed Social Security Amendments of 1956 (H.R. 7725), repeated the Advisory Commission's logic to explain the need for a separate matching formula and the elimination of the individual maximum:

> Since medical expenses for an individual may be high in one month (sometimes running to several hundred dollars) and small or nonexistent in other months, and since many of the individuals with the largest medical needs also have maintenance needs of $55 or more, there is frequently little or no Federal participation in payments made by States for medical care. This has limited the amounts of medical care that many States have been able to make available to recipients, and has certainly discouraged many States with less than average per capita income from assuming substantial responsibility for the costs of medical care for needy people. (84th Congress, 2nd Session, Report No. 2133, p. 29)

The Commission and Committee's summaries succinctly describe the basic economics of health care financing and insurance underwriting, in which the majority of costs are heavily skewed toward a minority of the population. The capitation of federal support at a low individual maximum—as opposed to an average capitation—made any sort of comprehensive program of medical assistance fiscally infeasible for many states.

Under the 1956 amendment, large medical payments made on behalf of some recipients could be averaged with the many small or no expenditures for other recipients. This in essence would create a reserve fund for the medical care of the needy. It could have a maximum value of $6 times the total number of eligible recipient and the federal government would contribute half. Any expenditure over this amount would be fully financed by the states. Now, assuming an actuarially sound trust that averaged $6 per welfare

recipient, a $100 doctor's bill could be paid entirely from the trust at a direct cost of $50 to the state, irrespective of the money payments allotted to the individual. Comparatively, prior to the enactment of the 1956 reform and assuming the OAA recipient received a cash payment equivalent to the national average of $57.99 per month (for December 1956), the state's cost for the same medical bill would have been the full $100 cost of the doctor's bill, having already exceeded the individual maximum eligible for federal participation (Statistical Abstract of the United States 1957).

After the bill's sweeping bipartisan passage in the House and Senate (passing 374-2 in the House and by unanimous roll call vote in Senate, with House concurring by voice vote to Senate changes), President Eisenhower signed the Social Security Amendments of 1956 on August 28.

The Social Security Amendments of 1958 (P.L. 85-850)

In a January 1958 letter to the newly ensconced chairman of the House Ways and Means Committee, Representative Wilbur D Mills (D, Ark.), the president of the American Hospital Association, Kenneth Williamson, acknowledged there existed a problem with respect to the access of the aged to health care services. While Dr. Williamson cautioned that any compulsory public hospital insurance program reliant upon Social Security payroll taxes "should not be accepted unless and until all other possible solutions of the problem have been fully explored and found wanting" it was significant that the he accepted that "the time is ripe for active Congressional consideration of the problem."[17]

[17] The American Medical Association was less relenting to accept the need for government intervention, but would ultimately give its support to the Representative Mill's 1960 proposal to extend the means-tested program for the poor.

While both the contemporaneous and historical attention to the biannual amendments to the social security act generally emphasized the social insurance provisions of the laws, the Social Security Amendments of 1958 (P.L. 85-850) is yet another example of the persistent incrementalism that expanded the federal grants-in-aid for the states' means-tested health care programs.

Similar to the delay between the 1948 report by the Social Security Administration recommending that maximum assistance for medical vendor payments be calculated on an average basis—as opposed to an individual—and the enactment of such reforms in 1956, the Social Security Amendments of 1958 represented the delayed enactment of a pair of reforms introduced four years prior by President Dwight Eisenhower in a special message to Congress delivered in January 1954.

Among the President's proposals for reforming the federal social insurance programs for the nation's elderly, President Eisenhower recommended, with respect to the federal grants-in-aid, that Congress adopt a new funding formula for all types of federal means-tested assistance that (a) calculated the maximum amount of federal cost sharing subsidies on an average rather than an individual basis and (b) took into better consideration "the financial capacity of the several States to support their public assistance programs by adopting, as a measure of that capacity, their per capita income" (Eisenhower 1954).

Whether or not the length of the delay was intended, the four intervening years between Eisenhower's special message and the enactment of its provisions with passage of the Social Security Amendments of 1958 would appear to fulfill the President's caution that the "new public assistance formula should not become effective until the States have had an opportunity to plan for it" (*Ibid.*).

With respect to Eisenhower's first recommendation, the far-reaching Social Security Amendments of 1958 authorized the states to include both the regular monthly money payment to recipients and any vendor payments for medical care in a "general averaging formula" based on averaging the payments for all

recipients in an assistance category rather than setting a maximum for each individual's payment. The total sum of welfare payments that the federal government would subsidize was determined for each categorical program by multiplying the respective number of persons receiving OAA, AB, and AD by $65 and by multiplying the number receiving AFDC by $30. These aggregate amounts replaced the respective $60 and $34 individual maximums for cash assistance payments and the respective $6 and $3 average assistance amount for medical care provided to an eligible adult or child.

Most important from the perspective of the development of Medicaid's cost sharing formula (i.e. the Federal Medical Assistance Percentage, or "FMAP") the 1958 amendments changed the calculus for how the federal government calculated its financial participation vis-à-vis the states by introducing the variable matching rate. The recommendation was for a broader application of the variable matching rate introduced on a more-or-less pilot program basis in 1946 for subsidizing the states' school lunch programs and hospital construction.

Prior to the 1958 the matching formula for medical vendor payments and cash assistance was constant across the nation.[18] But, now, with the enactment of the 1958 amendments, the federal government had the subsidies it provided to the states' welfare program better reflect the relative fiscal capacities of the states. This reform supported the view that a state's collective wealth, or the lack thereof, should not be the limiting factor in determining how much charity a state could show to its needy residents.

[18] The tiered subsidization schedule, however, had the affect that poor states that could not (or at least, choose not to) pay high assistance rates were liable for lower proportions of their total welfare expenditures. For example, in 1957 the states paid four-fifths of the first $30 in assistance for aged, blind and disabled recipients and fourteen-seventeenths of the first $17 for children, but they had to contribute a full half of the rest up to the defined maximum. States making high assistance payments could expect to receive as much as 65 percent of their assistance payments back in Federal grants-in-aid (less if they made payments greater than the maximum, any difference they would be wholly responsible for financing), whereas those with low individual payments would see upwards of 80 percent of their categorically needy assistance subsidized by the federal government.

Americans had a national responsibility to guarantee a basic level of subsistence to all their neighbors, irrespective of the state of their residency.

"[It] will be of particular assistance to States with limited fiscal resources and will enable these States to make more nearly adequate assistance payments," reasoned the House Ways and Means Committee in its report supporting the equalization formation. "This will help to more nearly balance the level of assistance made available to needy people in various parts of the country" (House Ways and Means 1958: 10).

While the federal share continued to be a generous four-fifths of the first $30 for adults and fourteen-seventeenths of the first $17 for children, for payments in excess of these amounts the federal government would variably reimburse a state according to a ratio of the state's income to the national income, bounded between a minimum of 50 percent and a maximum of 70 percent. The states would still be subject to the new average maximums for assistance set by the law. The federal matching percentage was to be recalculated every other year using a three-year average of per capita incomes according to this formula:

$$\text{Federal Share} = 0.5 \times \left(\frac{\text{state per capita income}}{\text{national per capita income}}\right)^2$$

Remarkably, the calculus underlying the federal matching formula would remain largely unchanged for the next sixty-plus years.

Despite the variability of the new formula bearing a resemblance to President Eisenhower's 1954 recommendation, his administration objected to the specific calculation of the federal share. The president opposed the calculation of the federal share because the formula, bounded as it was between 50 and 70

percent, had the affect of increasing overall federal participation relative to the states' status quo proportional financing of vendor payments.

During a hearing before the Democrat-controlled Senate Committee on Finance, the Secretary of Health, Education and Welfare, Arthur Flemming articulated the administration's opposition to the proposed changes to the matching formula. While the administration accepted that the maximum ceiling on state expenditures should be a variable calculation and computed on the basis of per capita income, the administration remained "strongly opposed" to the "unsound proposal" to amend the federal matching formula in the manner presented (*Ibid.* 112, 113).

The Secretary reminded the Committee that their proposal to reform the federal matching rate went counter to the President's earlier budget message for "modernizing the formulas for public assistance with a view to gradually reducing Federal participation in its financing" (*Ibid.* 112).

In preferring a reduction to the federal's government's commitment to welfare, the Secretary was referring to a proportional diminution of its fiscal responsibility, not an absolute reduction in federal outlays. The Secretary allowed for the likelihood that increased federal expenditures would be necessary; but he reiterated the perspective that if additional spending was needed to assist the poor residents of the states, the federal government should take a secondary, or tertiary (to local governments), role, not the primary role.

During the Senate hearing on the bill, Senator Robert Kerr (D, Okla.) sparred with Secretary Flemming over the necessity of increasing federal participation. The senator contended that the already inadequate health benefits received by the needy would necessarily be reduced if the Federal government required states to pay a greater proportion of the costs. Secretary Flemming, however, challenged Kerr and

others that he "would not start from the assumption" that the states could not do more for the poor (*Ibid.* 130).[19]

It was the view of the Republican administration that the health care needs of the states' poor were first and foremost the responsibility of the state and local governments.

Again, Secretary Flemming stressed the administration's primary objection was not over the absolute level of appropriation for welfare, but rather concerned notions of American federalism and the proper balance of administrative and financial responsibility for traditionally local welfare concerns. The Secretary rebutted the senators insistent on greater federal participation: "[T]his country has regarded these programs as State programs.... We are not objecting to an increase in the amount paid to the beneficiaries under this program. ...[W]e do object to the increase in the percentage of Federal participation" (*Ibid.* 141).

It is worth quoting at length a statement by the Secretary that exemplified the nuanced position of the Republican administration's philosophy toward the proper relationship between the federal and state governments and their respective fiscal and moral obligations to the poor. The national government, Secretary Flemming proposed, should set broad objectives and national standards, but the administration and financing of the public service should remain devolved to the states:

> ...the Federal Government has got a real obligation to set what I might call a national goal in an area of this kind and indicate what it is society as a whole, governments at all levels, and private institutions should be doing in order to deal with this problem in an effective manner.

[19] The relative merit of Secretary Flemming's own assumption was reinforced by the committee chairman, Harry F. Byrd (D., Va.) who noted for the record the relative fiscal health of the states and compared the states' finances to the recurring deficits of the federal government that was "not likely to have a balanced budget for many years" (*Ibid.* 134).

> On the other hand, I personally do not think that it is sound to see the States gradually move out of the picture from the standpoint of the assumption of fiscal responsibility or from the standpoint of making a contribution along fiscal lines to the achievement of these national goals.
>
> I think the Federal Government has made a real contribution to the achievement of these national goals. I think we should continue to do it. And I recognize the fact that even staying with the present percentage, or the present percentage relationship between the Federal Government and the State government, that the Federal Government may have to spend an increasing amount of money on it.
>
> But I think the time has come when we ought not to just let this curve of the percent of Federal participation keep moving up until it finally hits 80 or 90 percent because you and I know that if it does, this will no longer be an operation that will really be administered by the States and local communities. (*Ibid*. 143)

Not persuaded by the Secretary's testimony to limit federal participation, the Senate committee reported its bill with the enhanced federal match favorably to the floor. The Committee included a provision establishing an Advisory Council on Public Assistance that would review the status of public assistance in relation to old-age, survivors and disability insurance, the fiscal capacities of the states and of the federal government, and any other factors bearing on the amount and proportion of the state and federal shares of the public assistance programs.[20]

On the Senate floor, the public assistance components of the bill faced competing demands (see *Congressional Record* Vol. 104 Part 14 [1958]: 17973-17979, 17992). On the one hand, with the price tag of the public assistance component of the Social Security Amendments of 1958 estimated to be $288 million annually there remained real and legitimate concern among a bipartisan majority in Congress that President Eisenhower might still veto the bill as recommended by the Senate committee.

[20] It is worthwhile to note that a national health insurance model based on a social insurance model, such as that then was being pushed by Representative Aime Forand (D, R.I.), was excluded from the Advisory Council's mandate on means-tested programs.

A veto of the bill because of these specific welfare provisions threatened the enactment of the politically popular election-year increase in social security payments that was also included in the bill and for which the administration had given its consent. The consensus that seemed to emerge in parts of the Senate floor was that the only way to ameliorate the veto threat was to reduce the overall cost of the welfare components of the bill to less than a more palatable $200 million.

On the other hand, Republicans and Democrats from California and Massachusetts and the other comparatively wealthy states with the most generous benefits for their needy residents wanted to adjust the matching formula by increasing the maximum capitation on federal participation. They objected to the premise that a presidential veto was a certainty. The fact that their proposal further increased the magnitude of the federal appropriations demanded of the bill did not deter these senators.

As a member of this latter coalition, and splitting with the president, Californian Republican, Senator Thomas Kuchel, introduced an amendment to the Committee's bill costing an additional $40 million that would have raised the cap on federal participation to an average of $70 per recipient of OAA, AB and AD, and to $40 for each recipient of ADC—from $65 and $30 per month, respectively. Senator Kuchel's amendment did not change the new variable matching formula, but raised the maximum amount on which the formula would operate. The additional federal spending proposed by Senator Kuchel would largely go to states that traditionally had generous payments, such as California, Massachusetts and Colorado. These states were not particularly advantaged by the Committee's proposal to reform the federal-state partnership for means-tested assistance because the states already made welfare payments that exceeded the higher federal capitation levels. Such states would not see any fiscal improvement in changing from an individual- to average-based maximum. Further, the states that had more generous benefit schedules for their poor generally had higher per capita incomes relative to the national average and so they did not benefit from the introduction of the new variable matching grant, with its 50 percentage point

minimum rate, that replaced the constant 50-50 match. However, it was these very states that the president and his administration argued did not need any supplemental federal support given the states' own robust revenue sources.

Noting that his state's traditional generosity to its poor burdened California residents with high state taxes, Senator Kuchel passionately argued that his own amendment offered charitable Californians a "modicum" of relief that would help to resolve "the gross, indefensible, inequitable, and miserable manner in which aged citizens in some States of the American Union are treated by the bill, in contrast to the manner in which similarly situated elderly Americans in other States are treated" (Ibid. 17973).

Senator Robert Kerr (D, Okla.), who led the opposition to Kuchel's amendment, retorted, "I know that California has a great burden. It also has great capacity" (Ibid. 17976). And Senator Kerr assured his colleague, "I would love to help California nearly as much as I would love to help Oklahoma." Yet utilitarian concerns over a potential presidential veto forced him to be impartial, he explained. Despite the fact that "before too long Oklahoma would also become a beneficiary of [Kuchel's amendment]" as Oklahoma increased payments to the poor, Senator Kerr warned the Senate that no state "can become the beneficiary of a vetoed bill" (Ibid. 17976).

Not persuaded by such seemingly disingenuous charity when certain states, like Oklahoma, would receive an additional $10 or more per recipient from the Treasury, while others, like his home state of California, would get less than a dollar, Senator Kuchel reiterated that the "incredible inequity which exists in the committee bill is 100 percent indefensible."

Senator Kuchel added, "I do not see how Senators can approve such an elastic yardstick" and "abuse States in this Union which have tried to be, and have succeeded in being, a bit more fair and just with their fellow citizens in need" (Ibid. 17978). Fellow Californian and Senate Minority Leader William Knowland

(R) similarly argued that the committee's proposed spending cap was "a gross discrepancy and inequity" (Ibid. 17975).

In truth, however, California's poor would continue to be better treated than most other poor across the nation because the state offered more generous welfare relief to its residents. The so-called "inequity" of the proposed reform fell upon the California taxpayers who necessarily paid high taxes to finance the state's relatively rich welfare payments. Such Californians, and the residents of other comparatively generous states, would see little to no tax relief from the proposed reforms to the matching formula.

Instead of reducing state taxpayer inequity, the Social Security Amendments of 1958 intentionally increased such taxpayer inequity by raising the tax burden of providing a certain level of welfare in a rich state, such as California, relative to a poor state, like Oklahoma.[21]

In general, the additional federal appropriations included in the Social Security Amendments of 1958 benefited states with average monthly payments at or below $65 and with per capita incomes below the national average. By associating a state's matching rate with its per capita income, the matching formula was intended to help raise welfare payments in those poor states that historically paid out comparatively low benefits. Wealthy states, that typically paid more generous benefits, would not be eligible for the higher match. Thus, Congress intended the variable matching formula to reduce inequities among welfare recipients in different states by subsidizing a larger share of the welfare costs in poor states and thereby incentivizing such states to raise their welfare benefits to the national average.

[21] Californian poor were not even the best off, if it is appropriate to refer positively to poverty in any situation: Connecticut was the most generous with payments to its elderly poor averaging $107.32 per month; California with OAA benefits averaging $84.02 was only the fifth most generous. The average monthly OAA payment across the nation was $66.55 in 1958. (Congressional Record 1958: 17978)

The absence of any real consideration to the formulation of the variable matching rate is striking. For the most part, the Senate accepted the simplistic ratio of per capita incomes—"the mumbo-jumbo of the involved so-called variable formula written into the bill " as Senator Kuchel referenced it (Ibid. 19793)—as a *fait accompli*.

"I do not think one can rewrite formulas on the floor of the Senate," Senator Knowland acquiesced.

However, in alluding to potentially competing factors that could also be considered and balanced in constructing an equitable matching formula, Senator Knowland added,

> I hope in the national interest something will be worked out to provide an equitable formula for the large and the small States, with respect to those which in some ways are economically better off, which perhaps have problems some other States do not have, and which have standards higher than some other States. (Ibid. 17975)

But in offering no suggestion as to what an alternative formula should include, Senator Knowland punted, suggesting only that, "following Congresses must give that matter consideration." (Ibid. 17975) The Californians could not have known that the simplistic ratio based strictly on per capita income would have managed to persist, largely unchanged, as the foundation for determining a state's share of its Medicaid and CHIP expenditures for over six decades, through to the present day.

In agreeing to put aside any further consideration of the appropriate calculus for the matching formula, the Senate debate focused on the level of the cap on federal appropriations and overall cost of the reform. The Senate defeated Kuchel's amendment to raise the capitations on a division (or standing) vote. (Ibid. 17979)

To further mollify the administration fiscal concerns over the total cost of the welfare component of the Social Security Amendments of 1958, Senator George Smathers (Fla., D) offered two "practical and sensible" amendments he saw as necessary compromises in order to "get something rather than nothing."

His first amendment lowered the maximum match from 70 percent to 65 percent, thereby lowering the potential variable matching grant to be awarded to the poor states and reducing the overall estimated cost of the welfare provisions from $288 to $217 million.

Senator Smathers' second amendment to the Committee bill eliminated an upward revision in the federal match for payments to dependent children that would have increased the amount of federal payments from fourteen-seventeenths of first $17 spent to five-sixth of the first $18 paid to recipients. By retaining the status quo for the first $17 of assistance Smathers' amendment cut the proposed increase in federal participation and further reduced the overall price tag of the welfare reforms to $197 million. Both amendments passed without any debate and on voice votes (Ibid. 17992).

As an aside, and a preamble to the Kerr-Mills Act of 1960, it was telling that Senator Smathers' amendment to maintain a lower cost sharing rate for the first $17 dollar of assistance applied only to payments for recipients of aid to dependent children, not payments to the recipients of old age assistance, or the blind or disabled. In the same vain, nearly all arguments pertaining to the need to increase the federal commitment to welfare were made in reference to old age assistance. Only Senator Kuchel referenced blind individuals, a small constituency that no doubt garnered public sympathy. The senators were uniformly silent in advocating for increased spending on behalf of children on welfare. When it came to welfare, and as shall be seen, medical care, the public and their elected representatives treated families and children differently that they did the aged, and to some extent, the disabled and blind.

With the estimated cost of the public assistance components of the Social Security Amendments of 1958 now falling below $200 million, thereby alleviating the senators concerns it would attract a presidential veto, the bill passed the Senate, 79-0. Having earlier passed in the House by a vote of 375 to 2,

albeit without the Smathers amendments, the House subsequently concurred with the Senate version by voice vote. President Dwight Eisenhower signed P.L. 85-840 on August 29.

Consistent with his special message to Congress of 1954, President Eisenhower accepted "the desirable principle of varying Federal matching of costs in accordance with the relative fiscal capacity of each State." However, as he calculated, "the effect of this change is very limited because the formula used results only in increases in the Federal share." Reiterating Secretary Flemming's concern that an over reliance by the states on the federal government's fiscal capacity would negatively impact the states' safety net, Eisenhower warned that the increases in the federal share, irrespective of the states' fiscal resources, "can lead only to a weakening of the responsibility of the States and communities," and their "financial responsibilities should be strengthened, not weakened" (quoted in Schottland 1958: 3). The preferences of the Republican administration for a realignment of the state and federal governments' respective financial responsibilities for the poor's safety net became clearer, if no more successful, during the subsequent hearings over the Kerr-Mills Act of 1960 reviewed next.

Social Security Amendments of 1960 (P.L. 86-778)

Changing the calculation of the federal government's net share from an individual to an average basis and introducing the variable grant formula, significantly increased certain states' ability to leverage federal resources. In 1955, vendor payments made by the 40 participating states and territories totaled $212 million ($1.7 billion in 2008-adjusted dollars; see **Table 2.1** above). Washington financed just $23.3 million, or 11 percent of the total charges. Thirty percent of all vendor payments were financed through state and local general assistance programs whose recipients were ineligible for any sort of federal cost sharing. Even after excluding these expenditures, federal grants-in-aid reimbursed just 15 percent of the

remaining vendor payments made on behalf of recipients in the four categorical assistance programs eligible for federal cost sharing. The proportionately low rate of federal participation was attributed, in part, to states having cash payments that on their own exceeded the maximum level of benefits eligible for federal cost sharing.

A clear trend from the data is that an increasing share of any new state spending on medical care went to the categorical assistance programs eligible for federal cost sharing and not state or local spending on general assistance that was not eligible for federal cost sharing. A similar pattern will be seen in most states with Medicaid and CHIP spending: at least through implementation of the Affordable Care Act's Medicaid expansion in 2014, almost all means-tested medical assistance is directed exclusively to children, pregnant women, older parents, and, to a lesser extent, parents. Adults, however poor, are typically ineligible for assistance.

By 1960, total vendor payments had more than doubled with 47 states and territories reported paying approximately $490 million dollars on behalf of their poor residents ($3.6 billion in 2008-adjusted dollars), inclusive of vendor payments paid through the states' general assistance not subject to any federal cost sharing. In total the federal government provided $200 million of that total in the form of grants-in-aid to the 40 participating state, with the federal share of the medical expenditures of the four categorically needy programs rising to just over half of the associated costs.

As the opportunities for states to leverage federal dollars for specific constituencies, the distribution of state dollars changed. State (and local) spending on general assistance, which remained the only source of medical care for most poor adults who were generally ineligible for categorical assistance, decreased as a relative share compared to previous years; but remained relatively high, accounting for about $100 million of the total vendor payments in fiscal year 1960.

Notwithstanding this steady increase in spending on the poor over the later half of the decade (averaging an annual compounded growth rate of 18.2 between 1955 and 1960), medical vendor payments remained substantively insignificant and "pitifully insufficient," according to a report released in January 1960 by the Advisory Council on Public Assistance that had been established in 1958.[22] Still, the Advisory Council was cognizant to the effect of medical inflation and recognized the increasing fiscal import that health care costs would have on the aggregate welfare expenditures of the states. Their report included the assessment, "Future public welfare costs may increase largely because of increasing medical care needs and costs" (Advisory Council on Public Assistance 1960: 14).

Consequently, among other recommendations, the Advisory Council suggested, "The Federal Government should exercise greater leadership in stimulating and encouraging States to expand the scope and content and improve the quality of medical care for which assistance payments are made to or on behalf of needy individuals" (Advisory Council on Public Assistance 1960: 14).

Despite acknowledging "the concern of President Eisenhower and others over the continuous rise of the Federal proportion of public assistance funds over the years," the Advisory Council nonetheless recommended that the federal matching rate should not be decreased because much of the unmet need was concentrated in "the very place where it is least likely to be met by the State or locality" (*Ibid.* 16). As the Council significantly observed, "For several low-income States, average personal income is actually less than some high-income States' average public assistance payments per recipient" (*Ibid.* 18).

[22] For the month of March 1959, the average expenditure for the permanently and totally disabled were $9.75 per recipient, for old people $8.15, for the blind $4.96 and for dependent children $1.69. Comparable averages for general assistance recipients were not available. To give these amounts, unadjusted for inflation, context the authors of the report note that these figures are "indication of unmet need" explaining that "in comparison with what anyone knows from personal experience about the cost of hospitalization, nursing home care, drugs and physicians' services, the sums expended show up as pitifully insufficient" (Advisory Council on Public Assistance 1960: 14).

The Advisory Council's report reflected a general consensus among politicos that government needed to do something about the health care access for the poor, particularly the elderly who tended to be poorer and sicker, on average. If not with respect to certain specifics, the Advisory Council's recommendations can be traced throughout the congressional hearings of 1960 (and later, the hearings of 1964-65 that preceded Medicare and Medicaid).[23]

The Social Security Amendments of 1960 (P.L. 6-778) significantly, if again incrementally, augmented the federal government's role in financing health care of the aged and poor by increasing the federal grants-in-aid for recipients of Old Age Assistance and creating a new opportunity for the states to direct health services to this constituency. With respect to the aged, the legislation reintroduced the separate match for vendor payments with the maximum amount of medical care spending eligible for federal cost sharing set at $12 per recipient, measured on an average basis. Evidence of the political preference of older Americans, the 1960 reforms left unaffected the vendor payments for the programs of aid to the blind, permanent and totally disabled and dependent children that continued to be averaged with cash payments.

Enactment of Medical Assistance for the Aged: Kerr-Mills Program

[23] Others recommendations made by in the 1960 report by the Advisory Council on Public Assistance were included in Social Security Amendments of 1965. For example, noting the disparity in spending on different indigent categories—with old age people getting relatively more adequate care compared to dependent children—the Advisory Council recommended the "equitable treatment among categories" and application of the same assistance standards to all needy persons without partiality to one categorical group compared to another—a policy that would be eventually incorporated into Medicaid in 1965.

More significant to the institutional development of Medicaid, the legislation also created the new program of Medical Assistance for the Aged (MAA), more commonly referred to as the Kerr-Mills Act after its chief architects, Representative Wilbur Mills and Senator Robert Kerr.

Ten years after the 1950 amendments had highlighted the related medical and financial problems of the elderly, this federal-state program greatly expanded the states' potential to provide means-tested medical assistance to certain elderly Americans who were ineligible for cash assistance welfare but still had health needs beyond what their moderate incomes afforded. There was no limit set on the amount that the states could spend on these so-called "Medically Needy" and have partially subsidized by the federal government.

For both OAA and the Kerr-Mills vendor payments, the Senate version of the bill that survived the conference committee maintained, for eligible payments, a 50 percent minimum for federal cost sharing and raised the maximum rate from 65 percent to 80 percent.

The Committee on Finance originally estimated that the MAA and OAA provisions of the Act would affect upward of 12 million aged Americans: the 2.4 million currently receiving old-age assistance and another "10 million who may, at one time or another, be in need of assistance paying their medical expenses" (Senate Committee on Finance 1960b: 2). Though in any year after it is fully operationalized only "an estimated one-half to 1 million persons among these 10 million may become ill and require medical services that will result in payments under this title," referring to Kerr-Mills programs (Senate Committee on Finance 1960a: 9).

The original cost estimate of the legislation's MAA and OAA provisions was $200 million in its first year after enactment (when relatively few states would have implemented the later program) and about $330 million when fully implemented (respectively, $1.4 billion and 2.4 billion in constant 2008 dollars).

Given the optimistic enrollment figures championed in Committee such estimates were unreasonably low; however, with actual enrollment being a small fraction of their expectations the estimate managed to be not far from the provisions ' actual costs.

Reaction to Kerr-Mills was mixed. "One of the best things about this bill is that it is bipartisan in origin," Senator Kerr said of his program of Medical Assistance for the Aged. "It is not the first choice of either the Democratic or Republican candidate for President but both the Republican and Democratic nominees have approved the provisions of the committee bill" (Shannon 1960).

Liberal Democrats in Congress who favored a national Social Security-based model for delivering health care to the old assailed the means-tested approach as a "pauper's oath" and inadequate to meet the general public's demand for comprehensive health insurance. Senator Paul Douglas (D, Ill.) characterized the limited policy as a "complete repudiation of the Democratic platform" (Haakinson 1960). Presidential nominee, Senator John Kennedy (D, Mass.) released a press statement voicing "keen disappointment" over the rejection of an amendment that he and Senator Clinton Anderson (D, N.M.) proposed and, similar to the Representative Aime Forand's proposal in the House, added to the means-tested program a social insurance program of medical care for the aged that would be financed by an additional ¼ percentage point payroll tax (Albright 1960).

Irrespective of the preferences of the Democratic platform and a plurality of the Democrats in Congress, the congressional liberals had to contend with an Eisenhower administration that steadfastly opposed to any system of national health insurance that piggybacked on Social Security. The Kerr-Mills Act was the only health reform that had a good chance of becoming law in 1960, particularly just months before a presidential election.

It is worth emphasizing, however, that even Senator Kennedy saw the means-tested program more charitably than might be presupposed by some of the more passionate rhetoric on the Left. While simultaneously pressuring for the more expansive social insurance proposal, Kennedy accepted the expansion of state aid as an essential supplement to his preferred policy. In a discussion of the proposed means-tested assistance, Kennedy articulated that a safety net of welfare medicine was integral to any policy of comprehensive health insurance. "The Finance Committee Bill is good as far as it goes. But it simply does not go far enough," he wrote. "Extension of the Social Security mechanism to health benefits for the aged is not a substitute for the Committee action; it is an addition to it. Together, these actions would provide help to all our aged—those under Social Security and those who are not" (Associated Press 1960).

Thus, in 1960, as it would be in 1965, means-tested medical assistance was seen as a critical, if less lauded, component to any social insurance model for health care. Even proponents of the later approach recognized that not everyone, aged or otherwise, who required medical care would be eligible and adequately served with social security alone.

Secretary Flemming seemed to be comfortable with an incremental approach, citing as "desirable" and "probably worth trying" the objectives of the means-tested approach embodied in Representative Mill's amendment to H.R. 12580 and championed by Senator Kerr (Committee on Finance 1960a). In contrast, during his 1960 testimony before the Ways and Means Committee, he relayed the president's veto threat of the more comprehensive Forand bill, stating: "I want to make it clear that as an Administration, we will oppose any program of compulsory health insurance" (Social Security Online). He would reiterate this implicit veto threat before the Senate's Finance Committee.

Eisenhower's Secretary was insistent throughout his multiple appearances before Congress that any national health insurance program needed to be financed with general tax revenues and jointly financed by

both the states and federal government, preferably with the richest of the former contributing a larger proportion. Of course, the much more limited means-tested program of Kerr-Mills shared these two institutional features—even if the administration would have preferred a different range establishing the federal match.

Given these restrictions, Secretary Flemming consistently maintained that the total cost of any of the competing bills was not the primary issue. Indeed, the administration own ambitious proposal for providing comprehensive care for the aged was frequently described by the press as a "budget busting bill" that was even more costly than the Democrat's social insurance model. Some senators on the Committee on Finance, however, doubted the sincerity of Secretary Flemming's perfunctory testimony lauding the administration's own belated substitute proposal.[24]

Interestingly, in defending his preference for a national health insurance program financed by general revenues over a payroll taxes, the Republican Secretary offered an unabashedly liberal defense of the administration's preferred financing structure. "Certainly as far as the Federal Government is concerned it means that they would be financed by relying to a very large degree on the progressive income tax," explained Secretary Flemming. "We think that that is fairer thing to do than it is to throw half of the burden on earnings of $4,800 or less [referring to the increased payroll taxes that would be required of the social security proposal]" (*Ibid.* 93).

[24] The administration's proposal, subsequently introduced as bill S. 3784 by Senator Leverett Saltonstall (R, Mass.) and offered as an amendment by Senator Jacob Javits (R, N.Y.) to the bill released by Committee on Finance, would have underwritten only the cost of catastrophic illness for the aged and been financed by a federal and state match (see copy of administration's bill inserted for record at Senate Finance Committee, 1960a: 62-70). Even more costly than Representative Forand's bill, the administration estimated that its plan would potentially cost an additional $1.2 billion a year, with the federal government's estimated share at $600 million. Representative Burr P. Harrison (D, Va.) referred to Secretary Flemming's "budget busting" bill as a "Townsend Plan-Rude Goldberg scheme…more socialistic, more unsound and ultimately more expansive than the Forand bill" (Lyons 1960). Similarly, Representative Boggs (D, La.), lambasted the administration's old age medical aid proposal as "even more radical than the Forand plan" (Chicago Daily Tribune 1960).

Given this rationale for the administration's funding mechanism, Democrats on the committee were put in the atypical position of reminding the Republican secretary of the progressivity of the federal tax code that already imposed a marginal tax rate of 92 percentage points on incomes of $80,000 or more (equivalent to $580,000 in 2008-adjusted dollars) *(Ibid.* 105).[25]

Despite this exceedingly high tax burden, the Secretary still accepted, "I think you and I would agree on this, I am sure, that our Nation is wealthy enough and has enough resources to assure adequate medical care for its aging" (*Ibid.* 94). Further, to counter the senators' subsequent rebuttals that the administration's logic for preferring general revenues was inconsistent with the regressive nature of the revenue raising mechanisms of many states that the administration's preferred policy also relied upon,[26] the Secretary offered his hope that the many states who currently "make very little use" of an income tax would, as far as additional revenues were needed to finance reforms, rely on a progressive state-level income tax as opposed to additional sales taxes (*Ibid.* 94).

Secretary Flemming accepted, "any Governor would be reluctant to face the problems involved in taking on an additional fiscal responsibility" (*Ibid.* 80). Indeed, a telegram sent by the 52nd Annual Governors Conference to the Senate confirmed Flemming's observation: the telegram cited the inadequacy of federal-state matching formula and urged the Finance Committee "not to increase the state's role and

[25] It is worth noting that the marginal tax rate for those earning about $36,000 and $40,000 was 53%. Comparatively, in 2008 the tax bracket maximum marginal tax rate was 35% and individuals earning $250,000 had tax rate of 33%.

[26] Senator Paul Douglas (D, Ill.) highlighted the regressive nature of the states' revenue mechanism that relied more heavily upon sales taxes: "So far as State revenues are concerned, that approximately 60 percent of State revenues are derived from the sales tax. These sales tax are arithmetically regressive, that is, those in the lower incomes pay a larger proportion of their income in sales taxes that those in the upper income brackets" (Senate Finance Committee 1960: 97). Earlier in the hearings, another senator quantified the percentage share of sales tax to total state revenues at 80 percent.

amend the House's version of H.R. 12580 to provide health benefits under the social insurance system" (*Ibid.* 161).

Of course, as Robert A Peters (2004: 457) noted, this was a predictable response. A rationale for the governor's support for a fully federalized solution was provided by Senator Jacob Javits (R, N.Y.) elementary observation that "[t]he State Governors are not eager to raise money for the purpose of paying their share of these programs if they can get them without doing so. So who would expect any other reaction? We could hardly expect anything else but the Governors should say 'Sure, let the Federal Government do it'" (Senate Committee on Finance 1960a: 161)

Nonetheless, the Secretary relayed the administration's "very deep-seated conviction that it should be a joint sharing of responsibility on the part of the Federal and State Governments just as we do it in the public assistance areas at the present time" (*Ibid.* 81). The administration's own preferred allocation of fiscal responsibility, which the Secretary had championed during the 1958 hearings and again argued for with respect to both the administration's own proposal and the Kerr-Mills program, put the federal share provided to the states between 33 and 66 percent, based upon the per capita income of the state relative to the national average. The Secretary pointed to the success of the funding arrangement of the Hospital Survey and Construction Act of 1946 (or the Hill-Burton Act) that was also based on a ratio of State per capita income to national per capita income and ranged from 33⅓ to 75 percentage points.

Significantly, however, the Secretary demonstrated that neither he, nor, presumably, anyone in the administration, had put much consideration into the specific computation of either the equalization formula used in the administration's own proposal or that recommended for the Medical Assistance for the Aged. During the Senate hearings, Senator Anderson argued that the status quo matching formula led to "quite a difference in the way States contribute[d]" to the medical needs of their poor residents. The senator then

asked Secretary Flemming if the reliance upon per capita income differentials among the states while, arguably, appropriate for cash assistance, should "apply in this field [of medical care payments]" (*Ibid.* 90)? The Secretary's answer, which exhibited more than a little bit of naivety about the potential impact that the matching rate would have on future federal-state cost sharing, was indicative of the cursory attention that has historically been given to the construction of the fiscally critical FMAP formula:

> I appreciate that this question of an equalization formula is certainly a debatable one and one on which good arguments could be advanced on both sides….Now personally *I don't have certainly dogmatic feeling relative to the exact nature of the formula* and also relative to the various factors that should be taken into consideration. It has been suggested that that in developing an equalization formula in this area you might very well take into consideration the percentage of aged in a State in relation to the total population of the State (*Ibid.*, emphasis added).

The 1960 hearings never returned to the specifics of the funding formula. And instead of accepting the Secretary's suggestion of reducing the federal reimbursements to the wealthiest states in the Union, the Senate's Committee on Finance kept the 50 percent minimum and, further, amended the House bill with a more favorable matching rate for the nation's poorest states, increasing the maximum rate from 65 to 80 percentage points.[27]

Nonetheless, the administration's general preference for extending the shared financing arrangement triumphed over the social insurance approach after majorities in both chambers of the Democratic-controlled Congress were unwilling to endorse the later. The Democrat-controlled Ways and Mean Committee in the House rejected Representative Forand's amendment by a vote of 17 to 8. Since the committee's bill came to the House floor under a closed rule, representatives could neither offer an amendment nor vote specifically on the social insurance model in the Forand bill. Then despite the

[27] Where the state aggregate average payments for Old Age Assistance recipients were less than $65, the federal share for the medical vendor payments would be further increased. Such states would see their existing federal cost sharing percentage rise by an additional 15 percentage points such that in these states with low overall payments the federal subsidization for medical service costs would range from 65-to-80 percent.

Democrats' two-to-one majority in the Senate, the Anderson Amendment, having already been rejected by a vote of 5 to 12 in the Committee on Finance, lost by a vote of 51 to 44. (Incidentally, a vote on an amendment offered by Senator Javits that embodied much of the administration's—including the then-Vice President and Republican nominee for president, Richard Nixon—preference for a voluntary federal-state-aided system of health insurance also failed, with 67, including every Democrat, to 28, voting against the proposal.)

Both Representative Mills, of Arkansas, Senator Kerr, of Oklahoma, were southerners and they both opposed the Forand and Anderson alternatives, respectively, to their bill. In fact, in the House, no representative from a southern district voiced support for the Forand proposition and in the Senate only Lyndon Johnson (D, Tex.) voted in favor of the Anderson amendment (Peters 2004: 448-449; voteview.org).

While some of the opposition of the southerners was certainly ideological, Peters (2004) reasoned that the hesitancy of the South to embrace the expansion of Social Security in 1960 to include health insurance was fiscally pragmatic. He argued that southern senators understood that approval of the Anderson Amendment would jeopardize the entire bill and such an "outcome was inimical to the interests of the southern states because a veto would have cost them millions of dollars in new federal money that typically did not require matching funds from state coffers" (2004: 456).

Further, the potential state-level savings associated with the Democrats' health reform would be less immediate in the south. Until the 1950s most agricultural workers had been ineligible for OASDI and therefore the rural south generally had a lower proportion of its elderly collecting social security and a higher proportion on public assistance compared to other regions. This contributed to the geographic "divergence of state interests with regard to national health care policy" because fewer southerners would

be eligible for any social security-based health insurance (Peters 2004: 239). As Peters calculated, "States with the most rapid rates of caseload transfer [from OAA to OASDI] had a vested interest in pursuing the established of Social Security health insurance. Jurisdictions with the slowest rates of transfer, on the other hand, could maximize the flow of federal funds by advocating higher federal reimbursement for public assistance health care costs" (Peters 2004: 439).

Also relevant to the long-term fiscal calculus of the southern legislators was the fact that unlike either the Forand or Anderson Amendments (as would also be true of the later Medicare legislation), the means-tested vendor payments could be used to reimburse a wider range of services, such as long-term care and prescription drugs. Prescient legislators could sensibly expect their state and local jurisdictions to need to continue to finance such health care expenditures even if a limited national health insurance eventually passed. It was in the fiscal interest of legislators from comparatively poor states to secure an increase in the federal match while it was being offered. The upward revision of the maximum federal matching rate included in the Senate's bill favored the South because the region was generally poorer on average than the industrial north and had a greater proportion of elderly on public assistance. [28]

Table 2.2 summarizes the variation across southern and non-southern states with respect to their demographics and consequent impact of the Kerr-Mills Act on the state's variable federal matching percentage (for OAA and MAA vendor payments). The table also shows the number of OAA and OASDI

[28] Consider Louisiana and Mississippi. These southern states had two of the most liberal OAA programs in the United States with 57 percent and 49 percent of their respective elderly populations receiving means-tested benefits. Both states received the then statutory maximum federal matching rate of 65 percent for their vendor payments and could expect their respective matching rate increase 72 and 80 percent. (It is worth noting that Representative Mills' own state saw its federal medical matching percentage increase to 80 percent; although Senator Kerr's state of Oklahoma only saw a marginal increase in its federal share from 65 to 67.54 percent.) With no additional state-level spending the Department of HEW estimated that Louisiana would receive nearly $13.0 million in additional federal transfers for the medical costs of OAA recipients; and Mississippi, which previously did not have a vendor payment program, could expect $5.7 million in vendor payments at cost of just $1.1 million to the state and its local governments.

recipients (including disabled individuals under 65) as a share of the states' population over 65, and the gain in federal transfers per resident that each state could expect if Congress adopted the Senate Committee on Finance's bill (Senate Committee on Finance 1960b: Table B; Epstein 1962).

Table 2.2. Summary of aged population, Old Age Assistance ("OAA") and Old Age, Survivors, and Disability Insurance ("OASDI") recipients, then-existing and proposed Federal matching percentages, and estimated increase in federal grants-in-aid for states under Kerr-Mills proposal released by Senate Committee on Finance (for Fiscal Year 1961)

	Aged 65 and older, %	OAA Recipient, % of Aged	OASDI Recipient, % of Aged	Avg. status-quo federal-match applicable under OAA, %	Avg. federal match under Committee bill, %[1]	Avg. effective federal match for OAA under Committee bill, %[2]	Avg. increase in federal funding for OAA vendor payments under Committee bill, $per capita[3]
Southern States	8.7%	24.8%	77.5%	64.4%	73.1%	77.9%	$1.32
Non-Southern States with Senators voting for Anderson Amendment	8.7	12.2	84.5	54.3	54.8	58.5	0.69
Non-Southern States with Senators opposing Anderson Amendment	9.5	10.2	82.1	56.7	57.6	62.2	0.65

Notes:

1. These matching rates would be applicable to the new Kerr-Mills program and to vendor medical costs under OAA when a state's average total assistance payments (including cash payments) is over $65 per month.
2. When average total assistance payment is $65 or less the Federal matching percentage shown in this column would be applicable.
3. The Department of HEW also computed the additional state and local costs that would accrue from revised federal matching percentages. These were negligible with respect to additional vendor medical costs for OAA. As for MAA, any estimate of costs was assumed unreliable because it was "extremely difficult to estimate exactly which States will participate and to what extent, especially in the 1st year after enactment" (Senate Committee on Finance 1960b: 11)

Source: Senate Committee on Finance 1960b: Table B; Epstein 1962

Nearly a quarter of all older aged residents in southern states were recipients of OAA welfare; this was more than double the rate of take-up in the non-southern states. Further, the southern states had a slightly lower proportion of its aged collecting social security, on average (percentages used in Tables include survivors and dependents who are not necessarily over 65).

The biggest variation is seen, however, in the comparing the revised Federal matching rates. Prior to 1960, 12 out of the 14 southern states received the maximum federal matching rate of 65 percent, compared to just 6 of the 36 non-southern states; thus the South was set to benefit much more greatly by any upward revision of the maximum federal match under the equalization formula. The Committee on Finance's bill boasted the average matching percentage for OAA vendor payments from 64.4 to 73.1 in the South. And any new Kerr-Mills expenditures would be reimbursed at the same rates. (Further, states with low cash assistance payments could get an additional increase in the federal share of medical payments made on behalf of recipients of OAA, bringing the average increase in the South to 77.9 percent federal match for that share of vendor payments when summed with cash payments totaled less than $65 per month, on average per recipient.)

Enactment of the committee's amendment meant that with very little, if any, additional state or local expenditures the South could expect to receive significantly more federal grants-in-aid for medical vendor payments. Thus, a veto threatened an infusion of federal revenues that averaged $1.32 per southern (and as much as nearly $4 per resident in Louisiana), compared to an increase in federal grant-in-aids that approximated half that amount in the rest of the country.

Subsequent to the votes on the Anderson and Javits' alternatives, and despite the contentious nature of those votes, the Kerr-Mills Act embodied in H.R. 12580 passed the Senate by an overwhelming vote of 91-2 on August 23. The bill had previously passed in the House under a closed rule limited debate with a sweeping bipartisan majority, by a vote of 381-23 on June 23. After an aborted filibuster by Senator Russell Long (D, La.) whose costly amendment to extend assistance for mental illness and tuberculosis was stricken during the inter-chamber negotiations, the House and Senate endorsed the actions taken by the conference committee. President Eisenhower signed the bill into law on September 13.

With the Senate debate on the Social Security Amendments of 1960 occurring subsequent to the party's presidential conventions and with both nominees' Kennedy and Nixon advocating for their preferred reforms, a need to confront the nation's health care problems had become politically and publicly important. Given the close attention given to Kerr-Mills, both as a stand-alone bill and as a component of a more expansive health reform proposal, it is myopic historicism to diminish the salience of Medicaid's political development to subsequent Medicare debates. Robert Peters aptly subtitled his study of the competing health reform policies advanced during the hearings and floor debates for the Social Security Amendments of 1960 as "completing the foundation for Medicare and Medicaid" (2004).

Chapter 3.

Title XIX and Early Proposals to Amend Medicaid's Cost Sharing, 1965-1969

Even after the enactment and implementation of a generous Kerr-Mills program, it was clear by 1965 that too many poor were getting too little health care. Despite optimistic projections, the problem was that the states provided care to just 264,687 aged people, less than 2 percent of the nation's elderly population, in August 1965 under the provisions of the then five-year-old Kerr-Mills (Reed 1965: 48, Table 15). Financially, total medical assistance—inclusive of moneys paid direct through both Medical Assistance for the Aged and indirect through Old Age Assistance—had increased to just $1.4 billion annually by fiscal year 1965 ($9.4 billion in 2008-dollars), averaging 2.8 percent of state-level general revenues. For its part, Washington reimbursed the states $760 million ($5.1 billion in 2008-dollars).

While of critical importance to the many Americans the Kerr-Mills program served, this immediate precursor to Medicaid fell far short of the original estimate that the program would insure upwards of 10 million elderly. Even the more conservative, yet presumably more realistic, estimate that Kerr-Mills should have shortly expanded health insurance to an additional million individuals proved also to be overly optimistic.

This chapter proceeds from Medicaid's institutional heritage to its enactment and the immediate attempts by policymakers and policy experts to respond to the program's unanticipated costs by fundamentally reforming how it is financed. The first section looks at passage of the Social Security Act of 1965. With Kerr-Mills as its template, Medicaid was characterized as a modest reform that warranted little public or political scrutiny. Built on the social welfare programs that came before it, Medicaid was, in

Nicole Huberfield's assessment "remarkably path dependent" (2011: 449); or, as Judith Moore and David Smith summarized, "Medicaid had deep and strong roots" (2005: 45; see also Moore and Smith 2008). However, immediately upon implementation, policymakers observed an unanticipated increase in public expenditures: whereas Kerr-Mills never achieved its enrollment expectations, Medicaid would succeed beyond even its proponents' expectations. In fact, within months of the enactment of Medicaid, expansive participation in the program would cause its costs to eclipse its annual budget projections and federal and state policymakers would worry about its sustainability.

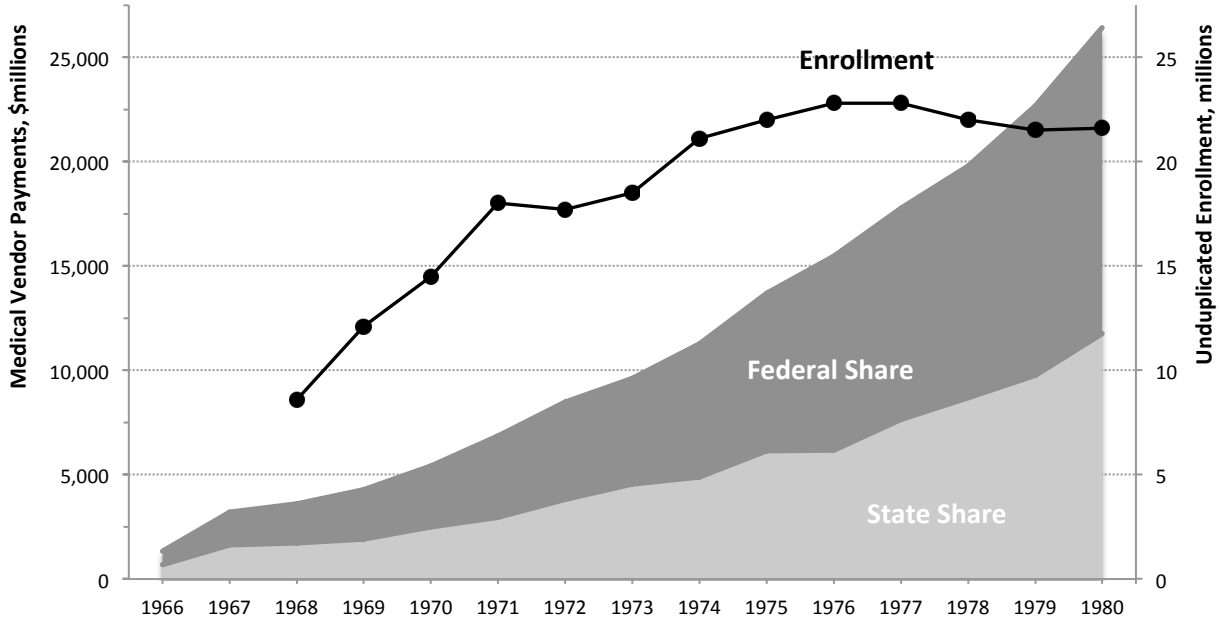
Responding almost immediately to these fiscal concerns, Senator Russell Long, a Democrat from Louisiana, would make two attempts, in 1967 and 1968, to mitigate the inefficiencies of Medicaid's open-ended cost sharing formula by increasing the proportion of expenditures paid for by the states and limiting the federal government's fiscal liability by mitigating the Treasury's exposure to state largesse. Both of Senator Long's attempts would narrowly fail. Instead, Congress imposed a capitation on Medicaid eligibility, leaving the program's cost sharing formula unaffected.

Following Senator Long's failed appeal to fiscal conservatism and the greater devolution of fiscal responsibility for the provision of health care to the poor to the states, the Nixon administration appointed a task force in 1969 that counter-intuitively—given its Republican genesis—recommended that the federal government assume full responsibility for Medicaid financing. With the Congress' attention still on how to better reduce the federal government's exposure to high Medicaid costs, the task force's recommendation was a non-starter.

Medicaid's status quo funding arrangement would remain unchallenged during the 1970s and so the chapter concludes with a brief overview of the decade. **Figure 3.1** presents aggregate expenditure and enrollment data for the Medicaid's first 15 years, 1966-1980, which are the focus of this chapter. While

enrollments plateaued by mid-1970, following the general saturation of the eligibility criteria, Medicaid costs continued to rise uninhibitedly at both the state- and federal-level. In particular, with an increasing proportion of state revenues being consumed by health care spending policy, a new chorus of policymakers' would raise concerns over Medicaid's fiscal sustainability.

Figure 3.1. Federal and State Medicaid Payments and Medicaid Enrollments, FY1968-80



Note: Prior to 1969, medical vendor payments include some non-Medicaid vendor payments (i.e. for Kerr-Mills and other means-tested medical programs
Sources: Table 3-4 and Table 3-7 from Advisory Commission on Intergovernmental Relations 1992 Medicaid Intergovernmental Trends and Options Report A-119

Social Security Amendments of 1965 (P.L. 89-97)

Even if Medicare and the provision of a system of universal health care for the aged was the national priority of Democrats through the Sixties, all the preceding legislative successes that had impacted the public delivery of health care came from expanding the means-tested federal-state safety net. While the absolute level of spending remained low throughout the mid twentieth century—thereby suggesting that

the delivery of medical care to the indigent was a marginal priority for state and local welfare agencies and even less of a priority for the federal government—a precedent for the shared federal-state financing and provision of health care to the poor had clearly been established in the decade and half prior to the enactment of Medicare.

During the debates on the Social Security Act of 1965, most of Congress and certainly most of the press and public perceived Title XIX to be simply another modest expansion of the American welfare state. With only flagging enrollments as the policymakers' guide, Medicaid—contemporaneously thought as "Title XIX: Grants to States for Medical Assistance Programs"— was understandably perceived, like its many predecessors, as just another incremental, even marginal, expansion to the nation's system for providing welfare medicine. Medicaid was presumed to be fiscally and programmatically inconsequential relative to Medicare. Similar to the Kerr-Mills program and those programs before it, Medicaid's institutional structure was consistent with certain well-established administrative and financial arrangements. Indeed, Title XIX exemplified a pragmatic reform agenda. While Medicaid removed certain fiscal barriers that had previously inhibited the federal and state governments from being more proactive, the program was not perceived as upending the status quo.

In stark contrast to the cacophony over Medicare, Republicans and the American Medical Association pragmatically and uncharacteristically lauded the expanded social welfare program of Medicaid. By addressing the inherent inability of the nation's employment-based health insurance market to cover the unemployed and retired, Medicaid was accepted as a necessary bulwark against greater government involvement. And for the doctors and hospitals who otherwise decried Medicare, Medicaid offered a source of public revenues to fund what otherwise was uncompensated charitable care that they were already providing.

The relative salience of Medicaid and Medicare, was exhibited in the fact that President Lyndon Johnson did not even feign to mention Title XIX in his signing statement, beyond a single opaque reference that explained how the Social Security Amendments of 1965 would, more generally, "improve a wide range of health and medical services for Americans of all ages" (Johnson 1965). This political obfuscation, unintended or otherwise, has been a common characteristic of public policy making around Medicaid.

Yet, Medicaid's lack of public or even political salience should not be mistaken for its limited policy salience. Adapted to the more urgent needs of the poor and rising costs of health care, Medicaid allowed career administrators and sympathetic congressmen in Washington, in partnership with the states, to expand the public's safety net and achieve their ambitious social welfare objectives of expanding access to health care. As Margaret Greenfield contemporaneously noted in a 1968 monograph on the Social Security Amendments of 1965 and 1967, the potential import of Medicaid to the health care sector and poor people was not lost on everyone. Even with Medicaid still being a negligible public commitment relative to Medicare, Greenfield wrote: "Although Medicare received more attention from the public, the welfare experts regard Medicaid as a greater social gain in that it could facilitate the eventual provision of medical care for all needy persons" (Greenfield 1968: v).

Similarly, the Ways and Means' Committee's described Title XIX determinedly, as "a greatly expanded medical care program for the needy and the medically needy" that was designed to correct the "failure of some States to provide coverage and services to the extent anticipated" for the Kerr-Mills program. The Committee Report lauded Title XIX for "undergirding the two new insurance program," referring to Medicare's Part A and Part B (House Ways and Means 1965: 23).

"Acutely aware of the inadequacies of the State medical assistance plans in the 1960s," former U.S. Secretary of Health, Education, and Welfare, Wilbur Cohen explained that the eligibility criterion of

Medicaid was purposefully left ambiguous (Stevens and Stevens 2008: 50). In fact, certain language included in the Social Security Amendments of 1965 all but compelled the states to be ambitiously generous in how they interpreted the ambiguity.

As enacted in 1965, Section 1903(e), "Payments to the States," directed,

> The Secretary *shall not make payments…unless the State makes a satisfactory showing* that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and *in the direction of liberalizing the eligibility requirements for medical assistance*, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources (Sec. 1903(e) of Social Security Act, as enacted in 1965, emphasis added).

How far a state expanded its eligibility depended only upon state lawmakers' interpretation of "liberalizing."

While the number of poor and near-poor recipients enrolled in the state programs was expected to reach "about 8 million," at least some prescient policymakers recognized how the Act's permissive language opened the potential that "states could, in the future, provide aid to as many as twice this number who need help with medical costs" (Senate Committee on Finance 1965: 3). In deferring the Medicaid's eligibility determination to the states, it was state-level policy decisions that largely determined aggregate Medicaid spending in the program's initial years. Within five years the enrollment projection of 16 million members was already. By fiscal 1973, over 20 million Americans were enrolled in Medicaid.

Incentivizing the states to be liberal in establishing their enrollment criteria, the law guaranteed that the federal government would subsidize all vendor payments made on behalf of eligible Title XIX residents in any participating state. The mechanism by which federal funds was to be distributed to the states being an extension of the variable grants-in-aid that had been used for Kerr-Mills and certain other welfare

programs. Based on the Federal Matching Assistance Percentage (FMAP), the federal grants-in-aid would no longer be capped—neither on an individual nor on an average basis. This absence of any limit on the amount of federal funding available to the states exasperated the federal government's potential fiscal liability.

The only revision that was made to the matching formulary was a modest revision upward in the FMAP that reduced most states fiscal liability for its Medicaid program. The revision marginally increased the federal share so that states with an average per capita income received 55 percent (up from the existing 50 percent rate) of their costs from the federal government and took the following form:

$$\text{Federal Share} = 0.55 \times \left(\frac{\text{state per capita income}}{\text{national per capita income}}\right)^2$$

States with the lowest per capita income could receive up to 83 percent (rather than 80 percent maximum allowed prior to 1965 for the Kerr-Mills program). The wealthiest states in the nation would still receive the minimum 50 percent federal subsidy for any Title XIX spending by the state.

The nature of this non-capitated federal match diminished the ability of Congress and the administration to maintain control over its Medicaid-related costs. Yet, still, and incongruent with even with the more modest enrollment expectations, the federal actuaries estimated that even "if all States took full advantage of provisions of the proposed Title XIX, the additional Federal participation would amount to $238 million" in 1967, its first full year of operation (House Ways and Means 1965: 85). Further, given reasonable delays in both implementing certain state plans and enrolling individual recipients the actuaries expected that the actual federal outlays would more likely increase by only $200 million over current law. Relatedly, the actuaries estimated that even with state governments financing an average of 47 percent of the aggregate Title XIX expenditures, state level spending should increase less than $200 million in first

fiscal year. This lower number was attributed to the expectation that some states would simply shift current budget items so that formerly unsubsidized state expenditures would now be partially reimbursed.

It is worth noting that the government's estimates for the additional outlays attributed to Title XIX, even when the amount is left unadjusted for the intervening seven years of medical care inflation, was less than the estimated cost of the modest technical reforms modifying the matching formula in 1958. Incredulously, the short-term budget estimate for Medicaid amounted to less than a 20 percent increase in federal outlays over the previous year for its predecessor programs, despite the introduction of a more generous matching formula and the estimate of an order-of-magnitude increase in the number of new beneficiaries.

To put into perspective the optimistically low nature of the estimate for Medicaid's total cost, it is worthwhile to compare the federal government's budget projection for Medicaid to that of Medicare: with respect to the new Medicare program, approximately 19 million Americans were expected to qualify in fiscal year 1967, at an estimated net cost of about $3.4 billion: $2.2 billion for Part A, the mandatory hospital insurance program, and $1.2 billion for Part B, the optional supplementary medical insurance program (Cohen and Ball 1965).

Given the nature of how the Medicare program was to be financed—in part, through the formation of a Medicare trust administered in the same manner as the social security trust fund—the actuaries' budget estimates were intended to be sufficiently conservative so as to better guarantee the long term fiscal solvency of the new program. For example, a 1965 House Ways and Means Committee report on the actuarial basis for Medicare declared that "Congress has very carefully considered the cost aspects of the proposed hospital insurance system" and that "Congress very strongly believes that the financing basis of the new hospital insurance program should be *developed on a conservative basis*" (House Ways and Means 1965,

emphasis added). Nevertheless, despite such overtures of conservatism and an acknowledgment of the fact that hospital costs were rising faster than wages, the committee report dismissed the impact of such inflationary pressures on Medicare's long term cost trajectory. With the hindsight of half a decade of medical inflation, the naivety of the following passage from the committee's report is evident:

> It is inconceivable that hospital prices would rise indefinitely at a rate faster than earnings because eventually individuals–even currently employed workers, let alone older persons–could not afford to go to a hospital under such cost circumstances….Quite obviously, it is an untenable assumption that there can be a sizable differential between the increase in hospitalization costs and the increase in earnings levels that will continue for a long period into the future. (House Ways and Means 1965)

The House Ways and Means Committee concluded that it was a "reasonable" and "conservative" assumption that the difference between the rates of increase for wages and hospital costs would disappear by 1975, after which wages and hospital costs would rise at the same rate.

Although the committee's report emphasized the actuarial assumptions behind Medicare's trust fund, the underlying healthcare costs trend would also affect Medicaid spending and thereby its projections. While it an undocumented supposition, it is reasonable to presume that the federal government's discounting of medical inflation was likely to have biased state policymakers to establish eligibility and benefit criteria that were more generous than would have been had state policymakers had a better appreciation of the future cost and therefore fiscal sustainability of their policy decisions. When defining its annual budget, a prudent state government prioritizes its fiscal commitments. Therefore, a state's Medicaid budget and its Medicaid policies should, theoretically, be based around a defined and finite budgetary allowance and respond predictably to deviations away from the state's predetermined prioritization within a broader global budget. However, the combination of a generous federal matching rate and the federal government's optimistic actuary projections had significant, and persistent, ramification on Medicaid budgets, specifically, and state (and federal) budgets, more generally.

To appreciate the dynamic relationship between artificially low initial budgets and high health care inflation, on the one hand, and generous cost sharing, on the other hand, consider this hypothetical example:

A state establishing its Title XIX program, sets its eligibility thresholds and provider reimbursements at levels so that its total estimated costs for the program is $10 million in 1966; given a 50% federal match, the state reasonably expects its own costs to be about $5 million. After just a few years of operations, however, it is apparent that costs greatly exceed the state's original estimates. In fact, actual spending on Medicaid totals twice the original budget at $20 million. The state's own cost have doubled to $10 million. If the state wanted to return to its original budgetary projections the state would need to make some politically difficult decisions that would effectively dismantle its Title XIX program. Further, for every dollar in state-level savings, the state would have to cut total Title XIX spending by two dollars. This would only come about by either taking away benefits from residents now receiving them or substantially reducing reimbursement rates to doctors and hospitals. Alternatively, instead of cutting $10 million in health care spending, the state could preserve its Title XIX commitments and cut $5 million in direct, unmatched, state spending elsewhere in the budget (or the state could raise an additional $5 million in revenue). It is always easier for government to giveth than taketh away; but if the state must taketh away, is easier to take $1 instead of $2.

In poorer states, that is, those states with a higher federal match, the state would have to cut total Title XIX spending by as much as 5 dollars for every dollar of state-level savings. For example, in our above example, a state with an 80 percent federal matching rate would have budgeted $2 million in state spending for its $10 million Title XIX program. If instead actual Title XIX spending were $20 million, the state's costs would have been not $2 million, but rather $4 million. For the state to return to its initial budgeted allowance, the state would need to cut $10 million. Or it could cut $2 million from education,

transportation, etc., or raise $2 million in additional revenues in order to preserve the $10 million in Title XIX spending.

The nature of Medicaid's funding arrangement that doubled, trebled, or more, the cost of any state-level attempt to reign in state spending made any attempts at retrenchment inherently difficult. This dynamic of expanding welfare medicine presumably on the cheap, then later discovering the policy is more expensive than initially bargained, but being incapable of redressing this oversight, has plagued policymakers responsible for administering Medicaid. It is this dynamic that will become a major component of the future legislative debates discussed in this chapter and the next.[29]

The absence of any substantial debate in 1964 and 1965 over Title XIX was not necessarily a legislative oversight. Reflecting on the 1965 congressional debates just a few years later, in 1968, Senator Carl Curtis (R, Neb.) portrayed the Medicaid debates as a myopic policy discussion. The senator described how "the entire [Medicaid] program was presented to the Committee on Finance with a minimum cost, at a time when the attention of the committee, was drawn to the two major parts of Medicare." With the benefit of hindsight, Senator Curtis was sufficiently emboldened to charge the Johnson administration with selling Congress a bill of goods. "I cannot believe that [the Department of Health, Education and Welfare] was totally unaware of the type of program they were ushering in," the senator critically argued, speaking on his chamber's floor while discussing potential reforms intended to curb the seemingly uncontrollable Medicaid expenditures. "There was not the disclosure made to the committee that there should have been." (Congressional Record 90-2 [1968]: 30089)

Nevertheless, regardless of the validity of the senator's conjecture, the relative silence around the program characterized the noncontroversial nature of Medicaid—a reform that was perceived to be just

[29] A more thorough presentation of the economics of the federal match as well as the economics of health care financing more generally in the United States is presented in Chapter Two.

another limited expansion of an already existing means-tested program that was acknowledged as an essential, if insufficient by most, bipartisan public policy.[30]

Senator Long Fails, Twice, to Revise Medicaid's Matching Formula

The Social Security Amendments of 1967 (P.L. 90-248)

By 1967, unexpected costs increases had compelled Congress to pass a supplemental appropriation for Title XIX of $470 million for fiscal 1967. Among the other causes that could have led to Congress and the state legislatures from underestimating their Title XIX expenditures, it is likely that in preparing their initial budgetary estimates for the program they had not anticipated the precipitous rise in medical costs—this being a reasonable oversight given projections of the federal actuaries, cited in the previous section. Notably, in 1966 and 1967, medical costs rose 6.1 and 6.7 percent, respectively; compared to 3.3 and 3.1 percent increases in the overall Consumer Price Index in the same two years (*CQ Almanac* 1969). In later years, the rate of inflation would frequently be in the double digits.

Despite just 37 states having implemented a Medicaid program, the nearly half-a-billion dollars in additional appropriations was already more than twice again the original appropriation allocated to the increased federal costs associated with Medicaid. Further, a committee report on the legislation included the prescient warning that "even this sum may be less than is required." Robert J. Myers, chief actuary for the Social Security Administration, cautioned that "without remedial steps" the federal cost alone for Medicaid would soon rise to $3 billion a year "or even more" (quoted in Smith and Moore 2008: 75, 76).

[30] As I will recount in the last chapter, a similar silence permeated, albeit less understandably given the accrued knowledge over its aggregate costs, Medicaid's integral relationship to the health insurance reform debated in 2009 and 2010.)

By the end of the fiscal 1967, the federal government's total share of the costs had nearly doubled over the previous fiscal year to total $1.4 billion, eclipsing all estimates for federal spending on means-tested health care by a factor of three. Medicaid spending by the states and federal government totaled $2.5 billion.

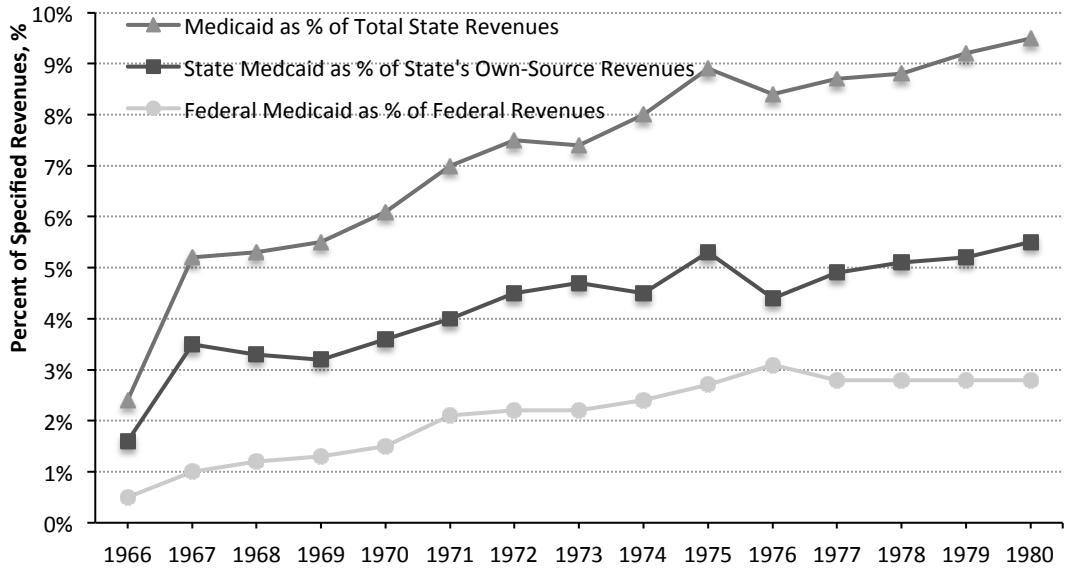
In those states that had already enacted Medicaid, vendor payments (including non-Title XIX programs) averaged 4.2 percent of the state's total revenues, with the state-share of the net expenditures accounting for 2.3 percent of the states' own-source revenues. In comparison, in states that had not yet implemented a Medicaid program, total spending on vendor payments equaled 2.3 percent of the respective states' total revenues in 1967, inclusive of all federal reimbursements (Commission on Intergovernmental Relations 1969: Table A-1 & A-2). The relatively low level of spending in the laggard states portended that the federal government would face escalating costs as these latter states implemented their own Medicaid programs before the 1969 deadline when the federal government would no longer reimburse non-Title XIX vendor payments. While state and federal administrators were already voicing fears of Medicaid's unsustainability, in reality, the share of state and federal revenues committed to Medicaid remained low as a historical share of government revenues.

Figure 3.2 charts the budgetary commitment of the states and federal government to Medicaid as a share of government revenues. For the period between 1966 and 1980, **Figure 3.2** shows the average percentage of a state's total budget committed to Medicaid and the average percentage of the state's own-source resources (i.e. excluding federal transfers, but inclusive of local government payments) that go toward financing the state-share of Medicaid expenditures. The figure also presents the total federal-share of Medicaid distributed to the fifty states as a share of the federal budget.

The share of the states' own-source revenues devoted to the state-share of Medicaid costs would more than double from an average of less than 2 percent in 1966 to over five percent by 1980. (It is worth

noting that this amount, however, remains less than third of the proportion of a state's own-source revenues consumed by the state-share of Medicaid today). More than the states' concern for the rise in the absolute level of expenditures on Medicaid, which were significant, it was this increase in the proportionate share of total revenues being redirected to Medicaid that legitimated concerns over the program's sustainability. Due to the common prohibition against deficit financing among the states and their need to mitigate the tax rate disparities between their neighbors, the states lacked the revenue raising abilities of the federal government and so there was an awareness that as long as Medicaid costs increased more rapidly than general revenues the program would necessitate a reprioritization of budgets.

Figure 3.2. Medicaid Spending as Share of Government Revenues, variously measured, FY1966-1980



Sources: 1966-1979: Committee on Ways and Means, House. 1985. "Medicare, Health Care Expenditures, and the Elderly."(March 15) 99th Congress, 1st Session Washington, DC: US Government Printing Office (Committee Report No. WMCP 99-6); 1980-2008 author generated from data requested from Centers for Medicare & Medicaid Services.

Whether or not fully justified, federal policymakers concluded that the primary cause for cost overruns was the unanticipated enrollment levels in some states, particularly New York and California. Congressional members lambasted New York in particular for setting its Medicaid eligibility at $6,000 for a

family of four,[31] thereby making eligible for Medicaid upwards of 8 million residents, or 45 percent of all New Yorkers. Whereas federal officials estimated that New York's Medicaid program would cost the Treasury $46 million (about one-quarter of the $200 million that Congress had originally budgeted as new Title XIX spending), as a result of its generous eligibility standard Albany estimated its inaugural federal cost would be nearly five times the congressional estimate, at $217 million (Sparer 1996: 79).[32] Like most healthcare-related budget estimates even this higher amount was overly optimistic of the state's ability to restrain costs: with "just" 3.5 million New Yorkers enrolling statewide by the end of 1967 total costs reached $461 million, approximately half of which were financed federally.

It was within this environment of perceived unsustainable cost and enrollment increases that Congress debated the Social Security Amendments of 1967 (H.R. 12080). The amendment of the original Title XIX legislation pitted two proposals for how to limit the potential growth of Medicaid costs by restricting, in two very different ways, the federal government's original commitment to the health care needs of the poor and near poor.

The proposal introduced in the House, and ultimately enacted by Congress and President Johnson, limited Medicaid eligibility to persons with household incomes no greater than 133⅓ percent of the state's maximum eligibility threshold for Aid to Dependent Children. In tying Medicaid eligibility standards to those of the states' means-tested cash assistance welfare program Congress rectified any potential ambiguity over the "liberalizing" mandate included in the original Section 1903(e) of Title XIX.

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[31] Comparatively, consider that in 2011, eight states—AK, AL, LA, MO, TX, VA, KA, and WV—still set their eligibility standards for adults *below $6,000 in current dollars*. And in all but seven states—AZ, CT, DE, HI, NY, VT, as well as the District of Columbia—childless adults were ineligible for their state's Medicaid program irrespective of household income (statehealthfacts.org).

[32] The two estimates are not fully comparable as Congress' estimate reflected only the additional cost associated with Title XIX. Previous expenditures for vendor payments that were rolled into Title XIX were not included in the $200 million estimate. In contrast, New York's estimate reflected the full cost of the state's Title XIX program that replaced some existing expenditures.

The Senate, however, originally passed an alternative proposal to restrain Medicaid. While it too capped enrollment (although not as severely as the House), more fundamentally, it affected federal cost sharing by adjusting the FMAP formula. Given the potential implications that this aborted reform could have had on amending the general fiscal relationship between the states and federal government, the Senate's amendment is worth exploring in greater detail.

Introduced by Senator Russell Long (D, La.), chairman of the Senate Finance Committee, the Senate's Medicaid-related provision differed in three significant ways from the House version. First, while the Senate's bill also reduced the states' potential Medicaid enrollment, it set the maximum eligibility threshold significantly higher, at 150 percent of the state's maximum old age assistance level (which was generally higher than a state's ADC eligibility criteria). Second, the Senate reforms would have allowed the states to impose deductibles and coinsurance rates on the Medically Needy thereby compelling recipients to not only pay part of their own costs of care but also, according to some health economists, audit the necessity of that care. Third, and most significant from the ad-hoc perspective of long-term cost analysis, the Long Amendment proposed a downward revision of the federal matching rate for Medically Needy—from the then-current 50-83 to 25-69 percentage points. The lower rate was calculated by squaring a state's standard matching percentage. The proposal left unaffected the federal match for categorically eligible Medicaid recipients who also received cash assistance.

Defending his committee's proposals against criticism of the cuts, Senator Long explained, "In my judgment, we have a right to do that when we finance these benefits out of general revenues. The cost of what we have now is too great…" (Congressional Record 90-1 [1967]: p. 33170)

As evidence of the states' largesse that needed to be reined in, Senator Long highlighted the following ad for Mount Sinai Hospital in New York City that the senator assumed any prudent member of Congress or taxpayer would agree was obnoxious in how it marketed its Medicaid health services:

> Attention: For most New Yorkers, the finest complete medical care is now FREE!
>
> Effective immediately, the Mount Sinai Hospital is offering the full benefits of the New York State Medical Assistance Program (Title 19).
>
> (Note: This is *new* and in addition to the Medicare Program of your Federal Government.)
>
> What this means to you:
>
> Unless your income is considerably above the national average, the total cost of almost all the same excellent medical care, services and supplies that Mount Sinai offers to any patient, will be fully paid by your State! (*Ibid*.)

"Of course, they do not mention that the Federal government is paying for half of that," exclaimed Senator Long, who defended his proposal to reduce the federal commitment by revising the matching rate as being "in the Federal interest and in the interest of the public in general" (*Ibid*).

With respect to New York, Senator Long's proposed reform would have transferred onto state governments and their taxpayers a greater proportion, but not all, of the fiscal burden of providing Medicaid to a sizeable subpopulation of New Yorkers who had household incomes above the state's welfare level and "considerably above the national average."

With the cautionary example offered by Mount Sinai Hospital in Manhattan, Senator Long hoped to demonstrate how the federal government's was incentivizing a pattern of sustained inflationary growth given the high degree of federal subsidization. Although New York had achieved only a fraction of its potential Medically Needy enrollment, its expenditure levels remained high. The state exemplified the

comparative savings that the Senate's proposal to adjust the federal-state matching rates offered over the House's marginally more restrictive eligibility standard. New York's exceptionally high level of spending per beneficiary was attributed to the state's comprehensive benefits package and its generous reimbursement rates that were made palatable to state budgets with federal assistance that lowered the state-taxpayer burden.

By maintaining original cost sharing for those eligible for the state's cash assistance programs, the proposal would not have affected federal fiscal commitments to those families that the states deemed truly destitute. But, the decrease in federal reimbursements and the potential increase in the state-share for a good proportion of Medicaid recipients would have necessitated that administrators, who set their state's eligibility criteria, benefits, and payments rates, and state-taxpayers, who are liable for the state's share of the costs, be more cognizant and discerning of overall spending levels.

"What the committee was proposing to do here was to permit the States to be liberal, as to whom it could extend the Medicaid program with Federal matching. But it would encourage them to economize," explained Senator Long. "If they wanted to be liberal with the program, that would be all right, but we would not put the higher amount of matching into that portion of the program (*Ibid*)." A state like New York could continue to offer a generous benefit package and maintain fairly liberal eligibility standards, but spending (on their optional Medically Needy recipients) would now cost them 50 percent more: every dollar spent on the Medically Needy would have had a direct cost of 75 cents to the state budget instead of the current 50 cents. In reality, by lowering the federal incentive per dollar of spending, the states would have been compelled to reduce their per capita expenditures. It is unlikely that most states would have increased their own spending to sufficiently compensate for the loss of federal support, thereby reducing overall spending and taxpayer burden for Medicaid.

In arguing for his proposal, Senator Long highlighted the real economic loss that many states experienced due to the interstate transfer of federal general revenues to a few states with overly generous Medicaid programs: "In this program, the poor States are contributing money to help support the liberal programs of the wealthy States (*Ibid*)." Sharing this divisive sentiment, Senator Carl Curtis (R, Neb.) critically added, "We must keep in mind that this Federal money is obtained by taxing all the people, including the States that cannot afford the program for those people already on welfare (*Ibid*, p. 33171)."

Forty years later, scholars Thomas Grannemann and Mark Pauly (2010) would offer empirical support for these senators' concern over Medicaid's interstate fiscal inequities. Granneman and Pauly's argument suggests that despite poor states getting a much higher federal matching rate and therefore paying a lower proportion of its aggregate Medicaid costs relative to the richer states, the residents of the poor states often still experience a net transfer of Medicaid-related federal tax dollars out of their states because of overly generous Medicaid programs in wealthy states.[33]

It should not be surprising that the most ardent defenders of the status quo in 1967 (and again in 1968), irrespective of party, were the senators from New York and California—the two largest states that with generous Medically Needy programs and a 50 percent match that would have been the most negatively affected by the proposed downward revision of the FMAP. In general, the nation's wealthier states would have experienced a far greater downward affect on their states already low FMAP rates due to the squaring of the rate: for example, New York would see its federal minimum FMAP drop 50 percent from 0.50 to 0.25, whereas, Mississippi, the poorest state in the nation, with an FMAP of 0.83 would experience a drop

[33] In the previous chapter, I have examined the economics of the FMAP funding formula from the theoretical perspective of the preferences of the states' and national median voter to argue that Medicaid's cost sharing causes an inherently inefficient allocation of public resources—albeit an intentional inefficiency that is meant to compel an increase in redistributive spending. In chapter 7 I critique Granneman and Pauly's conjecture with respect to the regressivity of the FMAP formula and argue that the while the transfer of funds may not be progressive in nature, it is not as regressive as the scholars conclude.

to 0.69, equivalent to just 17 percent of its original rate (of course, Mississippi had no Medically Needy program and so would not see any immediate drop in federal aid).

Senators Thomas Kuchel (Cal.) and Jacob Javits (N.Y.), both Republicans, accepted the prudence of limiting Medically Needy eligibility, but countered Senator Long's proposal as passed by the Senate's Committee on Finance. The senators offered an amendment to the Long proposal that would have eliminated the downward revision of the federal matching rate while maintaining the diminution in eligibility.

Senator Javits described the committee's bill to lower the matching formula as a "manifest discrimination and injustice" (*Ibid,* p. 33169). Senator Kuchel indignantly characterized it as "an assault on the intention with which Congress approved Kerr-Mills and amended Kerr-Mills" and pleaded to his colleagues to not "break faith with the people" who he presumed tacitly supported the expansions of federal assistance to the near-poor (Ibid, p. 33167). Similarly accusing his colleagues for "breaking our faith with" the American people, Senator Robert Kennedy (D, N.Y.) reminded the Senate that "when [Medicaid] was passed it was not aimed just at the poverty-stricken people of the United States,…it was also aimed at those in the lower income and lower middle income brackets" (*Ibid*, p. 33172). Despite the pleadings of these big state senators, their amendment to retain the existing matching formula was rejected in the Senate by a significant majority vote of 25 to 48.

The revised matching formula reflecting a reduction in the federal government's commitment to Medicaid was subsequently passed by the entire Senate as part of the chamber's version of H.R. 12080, the Social Security Amendments of 1967, by a sweeping bipartisan majority of 78 to 6.

However, upon further recommendation by Robert Myers, the federal actuary, conferees agreed to accept the House's proposal that had a lower eligibility cap but left the matching rate unaffected. Congress

took this action given Myers' calculation that implementing the House's more restrictive eligibility was likely to save the Federal Government a greater amount of money. It was estimated that reducing eligibility for the medically needy program to 133 1/3 percent of a state's maximum threshold for ADC eligibility threshold, would limit the Federal government's spending to $1.7 billion in fiscal 1969 ($10.8 billion in 2008-adjusted dollars; CQ Almanac 1967: 892).

Although unrelated to the legislative debate over eligibility and the matching formula, it is worth mentioning that the Social Security Amendments of 1967 also enacted what would become three costly, if essential, new Medicaid requirements that would overwhelm any cost savings associated with the law's new eligibility restrictions. The cumulative effect of these federal requirements and the introduction of mandates for other services over the decades guaranteed that per beneficiary costs would continue to increase in subsequent years.[34]

Tax Bill of 1968 (H.R. 11394)

Unfortunately, the need for consecutive supplemental budget requests within months of passage of the Social Security Amendments of 1967 frustrated Congress' hopes for restraining federal Medicaid

[34] The Social Security Amendments of 1967 introduced the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program that mandated an even more comprehensive benefits package for poor children eligible for Medicaid and would "become one of the most flexible and bounteous sources of funding of health care for children in poverty and almost, by itself, a separate entitlement" (Smith and Moore 2008: 78). The law also included the so-called "freedom-of-choice" requirement that allowed Medicaid recipients "to use providers of their choice, to enter the mainstream of American health care". Given the unprecedented increase that Medicare and Medicare imposed on the demand side with their millions of new consumers with near-unlimited entitlements to health care, the states would have to increase its average reimbursement rates if it wished to assure adequate doctor participation and remain in compliance with this mandate. Further, and among other minor reforms related to Medicaid, the Social Security Amendments of 1967 also expanded the role that Medicaid would play with respect to the nursing home industry by recognizing and defining an "intermediate care facility" (ICF) and making these institutions eligible for Medicaid spending while setting up a legislative basis for regulating these facilities.

spending. First a bill for an additional $300 million and then another bill adding $400 million increased the net appropriation for Medicaid in fiscal 1969 to $2.4 billion ($15.3 billion in 2008-adjusted dollars), over 40 percent beyond projection.

Reforming eligibility, alone, was clearly insufficient to control Medicaid costs.

Instead of just arbitrarily limiting enrollments to enforce savings, Senator Long's revision of the federal matching rate had been an attempt to fundamentally change the federal underwriting of Medicaid. Rightfully characterizing Medicaid as an "uncontrollable item" in the federal budget, Senator Long argued, "It stands to reason that it will get worse and worse.... And keep getting worse until somebody changes the law to put this thing back under control" (Congressional Record 90-2 [1968]: 27958).

Some comparative savings undoubtedly resulted from the more draconian eligibility restriction included in the House proposal, but as a cost saving measure the House's proposal was shortsighted. Given the magnitude of the accounting error, however, it is reasonable to criticize the policymakers for not having questioned the actuarial assessment reported in 1967. Even among those states that already had an expansive medically needy program the relative cost savings of the House's proposal over the Senate's proposal was dubious. For example, the Tax Foundation estimated that during fiscal 1968 approximately three quarters of New York's total Medicaid expenditures went to its optional medically needy recipients and so by halving the federal appropriation for this subpopulation, the Treasury would have reduced its total appropriation to New York by nearly 40 percent, assuming the state did not reduce aggregate spending. Corroborating this estimation, Senator Javits, who opposed the Senator Long's proposal to control Medicaid costs, quoted a state official that conservatively estimated that the version passed in the Senate

would have reduced federal reimbursements to New York by an additional $51.8 million compared to the House's version of the bill (Congressional Record 90-1 [1967]: 33172).[35]

"By yielding to the House language," lamented a vindicated Senator Long. "The program is now $700 million more than [the Department of Health, Education and Welfare] said it would cost" (*Congressional Record* 90-2 [1968]: 27690).

Although the federal government's chief actuary, Robert Myers, would partially defend his office's poor estimation of costs by pointing to the Medicaid's unanticipated enrollment numbers, Myers candidly acknowledged the base error of his estimate. "I regret to tell you that we were wrong," he admitted (quoted by Senator Long, *Ibid.* 27690). More critically, Senator Jack Miller (R, Iowa), characterized Mr. Myer's analysis as a "horrible estimate" of Medicaid expenditures (CQ Almanac 1969).

In support of Robert Myers and the nonpartisan Office of the Actuary, Senator Long accepted that a "good part" of Congress' inability to control costs could be attributed to "the connivance and cooperation of the Department [of HEW]" that allowed states to evade the enrollment limits set by Congress and "make all kinds of people eligible [for Medicaid] that nobody in Congress ever intended to make eligible: and went on to question, "whether the people over there are the kind of people who should be administering the program" (*Congressional Record* 90-2 [1968]: 30089).

[35] New York reduced its annual income eligibility cap for a family of four to $5,300 in 1968, and further reduced its cap to $5,000 in 1969, leading to a million New Yorkers being removed from Medicaid's roll and another 2 to 3.5 million losing their opportunity to enroll. However, New York's eligibility criteria remained nearly a thousand dollars higher than a 133⅓ percent of the state's maximum AFDC eligibility threshold and so it is difficult to estimate what would have been the relative cost of defining Medicaid eligibility at 150 percent of the state's maximum OAA payment. Thus, savings accruing from what amounted to an only marginally more restrictive eligibility threshold—relative to Senator Long's own proposed enrollment cap—should have been largely artificial.

Bolstering the senator's accusation of complacency by federal administrators, the Tax Foundation, after examining the eligibility criteria of the 21 states with Medically Needy programs, concluded, "The great majority of the state programs which include some medically indigent persons have been more liberal in their interpretation of the numbers needing care than is allowed for in the 1967 revisions" (Tax Foundation 1968: 53).

To emphasize his point, Senator Long used the example of Illinois' welfare office to demonstrate how states were effectively flaunting the federal government's intent to limit Medicaid eligibility to the very poor. Among some forty specific exclusions, Senator Long pointed out how households in Illinois could reduce their reported income for purposes of determining eligibility for ADC in special circumstances, and therefore for Medicaid generally, by the cost of restaurant meals, cod liver oil and vitamin D concentrate, housekeeping, storage of furniture, and life insurance premiums. Further reiterating his argument for the need to redress Medicaid eligibility, Senator Long presented data from those states offering a Medically Needy program under Title XIX.

Of the 20 states that already had such a program established in 1967, eighteen had made changes to the ADC eligibility threshold that served as basis for eligibility for Medicaid by 1968, with such adjustments translating into an average increase of 28 percent in the eligibility threshold for Medicaid over that one year. Senator Long characterized the states that had implemented a medically needy program as generally being states with higher per capita incomes, explaining:

> In other words, this tremendous expenditure is occurring in the states where there are relatively fewer needy people, compared with other States of the Union. That is perhaps the case because those States have relatively less needy people on the one hand and greater income on the other. With more matching money available to those State governments, those States are In a position to take a program of this sort—which, as welfare programs go would claim a lesser priority in a state with many needy people, relatively speaking—and

extend it to all sorts of people who were not expected by the Congress to be classified as medically indigent. (*Ibid.* 30088)

With costs continuing to escalate, Senator Long again proposed a reform to the Medicaid program in 1968, but without the regular social security amendments passing through his Committee on Finance, the senator attached his Medicaid proposal as a rider to H.R. 2767, a minor tax bill.[36] Undeterred by those senators who objected to the nature in which he introduced his proposal, Senator Long argued it was necessary get Medicaid's expenditures "under control" to "put this genie back inside the bottle, where it belongs." As Long explained, the money for Medicaid "has to come out of the hides of people for whom Congress voted money, in order to give it to somebody to whom Congress never intended to give the money" (*Ibid.* 27958).

Senator Long reiterated many of his past arguments for why the proposed cuts were necessary. This time, however, he made a more explicit appeal to the implicit fiscal trade-offs, or opportunity cost, that the nation's run-away Medicaid spending was imposing on the federal government due to the zero-sum nature of public finances.

Senator Long's proposal did two things. First, it tied Medicaid eligibility to the "average" or "ordinary" income threshold for ADC eligibility—as opposed to a state's maximum income threshold. Second, it carried over the lower FMAP rate for medically needy populations that he had introduced and

[36] H.R. 2767 was initially a bill dealing exclusively with the deductibility of assessments made by drainage districts on their members for property subject to depreciation. This bill that was finally passed by the Senate contained 15 other tax, social security and expenditure control amendments, including Long's amendments. However, there was not enough time for the House conferees to consider this many amendments; nonetheless, the House indicated its willingness to consider the drainage district provision itself as an amendment to another tax bill, Therefore, H.R. 2767 became public law under the heading of H.R. 11394. Actions like this lead to tangled legislative histories but sometimes are necessary if legislative action is to be completed on a bill as the Congress is drawing to a close. (Woodworth 1968: 79).

the Senate had approved in the previous session; Senator Long explained that this change would be responsible for the program's "big savings."

The first provision was an attempt to put some teeth behind the existing law by reducing the opportunity for states to manipulate what had been the intent of Congress to limit Medicaid eligibility. "We do not object at all to providing Medicaid to people on welfare," assured Senator Long. "This amendments affects the program where the State goes beyond the welfare rolls, to provide Medicaid to those who are not eligible for public welfare."

Compared to eligibility criteria, Robert Myers confirmed Senator Long's proposition that the downward revision of the FMAP formula would be "less manipulable" (Ibid. 27958). Myers estimated that this provision had the potential to save the federal government $500 million in 1968.

Defending the equity of tightening up the eligibility criteria and reducing the FMAP for the medically needy population, Senator Long explained, "In my judgment, there is plenty of money, under this amendment, to take care of those whom we intended to take care of, and, if the States want to be more liberal than we intended to be, let them put up a higher percentage of State money to be liberal with."

Not too surprising, the National Governor's Association opposed the Long Amendment, collectively resolving that it "strongly supports the funding of current Title XIX programs as originally indicated" (quoted in *Ibid*. at 29928).

Senator Long went on to describe how the current federal match encouraged the states to "take advantage of all this liberal Federal largesse, where the Federal Government pays up to 83 percent of the money, so that, by putting up as little as 17 percent State money, they get 83 percent Federal matching funds." Absolving the states of blame the senator reasoned, "Under those circumstances, they could hardly

afford not to put the money out" (*Ibid.* 27958). Lowering the amount of federal underwriting of the state' medically needy programs, "reduces the incentive for the State to try to keep boosting coverage up and up, because the Government will not be as generous as it has been before" (*Ibid*. 27959).

Countering Senator Long's amendment, Senator Clifford Case (R, N.J.), a moderate Republican from a large state with the national minimum FMAP rate, rejected the premise that the more liberal state programs, either in terms of their enrollments or services, went contrary to Medicaid's original intent. "We should not treat it as welfare," the Republican argued, referring to Medicaid. "[T]his program, which essentially is not a program for indigent people, is a program for extending to all people in the country the best kind of medical care this country can provide."

Sharing a similar perspective, Senator Javits (R, N.Y.) criticized the Long Amendment for going "a very long way toward completely nullifying the Medicaid program" (*Ibid*. 27960). Javits argued that Medicaid's flexible expansiveness was part of its bipartisan appeal. "When we adopted the program [of Medicaid]," he explained. "An effort was being made to stop Medicare, as well as possibly a much more comprehensive program for health care in terms of people of the United States" (*Ibid*.29925). In order to do so, Medicaid had to offer sufficiently robust coverage to serve as a necessary bulwark against fully socialized medicine.

Senator Long's two proposals in the 90th Congress represented the first time that either chamber debated on its floor the implications of the FMAP formula and the federal matching rates. However, the debate took place only in the Senate and it only lasted an hour in 1967 and 30 minutes in 1968.

Opposed as he was to the Long amendment, Senator Javits complained, "Certainly an effort to latch this in at the last minute of the last hour…seems to me to be rather ill advised." Javits pleaded that the Senate give the matter further consideration, explaining that "matters of such vital nature to individual

States and to millions of Americans certainly ought to have enough consideration that they ought to await the next session of Congress" (*Ibid*. 27958).

Just as Secretary Flemming acknowledged, in 1960, his own lack of "dogmatic feeling relative to the exact nature of the formula" in relationship to the Kerr-Mills program, it is worth noting how few in public office have ever seriously debated the profoundly significant implications of Medicaid's funding formula. The rarity of any attempts in the subsequent congresses to reform the funding formula can be attributed, in part, to the inherent challenges of retrenchment politics. The difficulties associated with Medicaid retrenchment are exasperated by the high degree of cost sharing that diffuses at least half of the savings enacted by a state across the nation. Because federal spending is paid collectively but directed to an individual state, the voters are not guaranteed to see any proportionate return for their state's reduction in its commitment to Medicaid.

No doubt, Senator Long's proposals to revise the FMAP formula would have effectively forced states to retrench their Medicaid programs. Had Senator Long's proposal been passed then state residents would haven been immediately burdened with a larger share of their elected legislators' Medicaid policy decisions. As such, if general economic theory and the median voter theorem are accepted as legitimate proxies for modeling rational political behavior, a potential result of increasing the states' direct costs would have been discovering the optimal level of Medicaid expenditures preferred by a majority of state residents. (Chapter 2 explores this dynamic from a more general perspective.)

The choices available to the states would then have been to increase taxes on its residents in order to raise additional revenues to maintain its current level of Medicaid spending, or to reduce services and/or reimbursements rates thereby lowering its aggregate Medicaid spending. The former would risk the ire of voters while the latter would challenge the political strengths of powerful interest groups (whether they be

doctors, hospitals, or the disabled or aged, by far the costliest beneficiaries of Medicaid). It is likely that a meaningful reform of the funding formula that would have led a combination of both increased taxes and reduction in services.

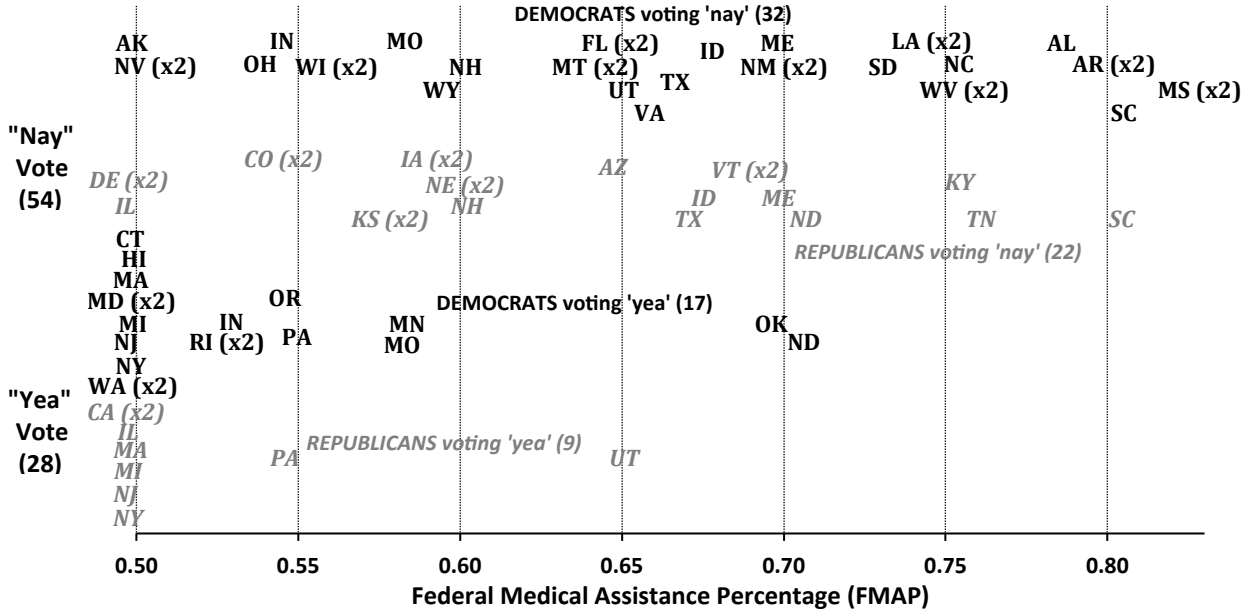
In the end, neither one of the two attempts to revise the FMAP formula that had been introduced by Senator Long and passed by his colleagues were ultimately enacted by the full Congress. Both amendments were removed from their respective bills during conference and were not part of the final vote.

Roll Call Analyses of Votes to amend FMAP in 90th Congress

Although both attempts to revise the FMAP formula in the 90th congress ultimately failed, the Senate debates and the two roll calls related to the revision are worth examining because the instances of serious, even if limited, debate on the federal matching formula are few.

Figure 3.3a and **Figure 3.3b** presents the individual voting data on the related roll calls in the first and second session of the 90th Congress. The "Yea" and "Nay" votes are presented for each senator according to their state and party. The horizontal axis plots the votes by the FMAP rate of the senator's state (included in the figures are the announced and paired votes recorded in the *Congressional Record*). In **Figure 3.3a**, a "Yay" for Senator Kuchel's amendment coincided with a rejection of Long's proposal and retention the status quo matching formula; in **Figure 3.3b**, a "Nay" vote had the same effect. These two votes could be considered the more liberal option.

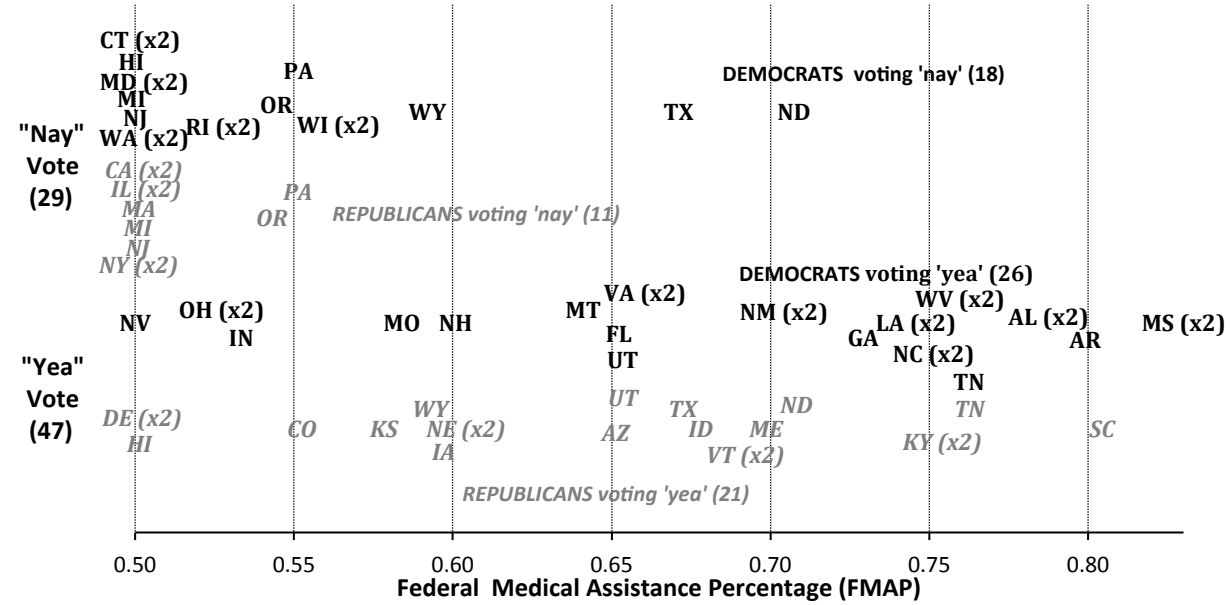
Figure 3.3a. 90th Congress, 1st Session - Roll Call No. 267 on KUCHEL AMENDMENT*, by party and state FMAP of voting senators (includes announced and paired votes)



Note: * To Amend H.R. 12080, by placing a ceiling on "medically needy" programs of the states, which would preserve the present law on federal participation, and by providing that "medically indigent" persons cannot have more income than 150 per cent of the highest type of welfare payment under the law of his state. (Nov 20, 1967, CR: 33174)

Source: voteview.com, variable 267 (excl. 3 paired votes and 3 announced votes, roll call was 25 "yea" to 48 "nay")

Figure 3.3b. 90th Congress, 2nd Session - Roll Call No. 297 on LONG AMENDMENT^, by party and state FMAP of voting senators (includes announced and paired votes)



Note: ^To amend H.R. 2767, by providing a revised formula for payments to states toward Medicaid program, and barring payments for Medicaid to individuals whose income exceeds an amount to be determined in accordance with certain standards. (Sept 24, 1968, Congressional Record, p. 27961)

Source: voteview.com, variable 0569 (excl. 4 paired votes and 2 announced votes, roll call was 44 "yea" to 25 "nay").

With defense for retaining the current level of federal participation in Medicaid being led by liberal Republicans from New York and California, partisanship was clearly not a strong determinative factor of the senators' votes: for the vote in the 2nd session of the 90th Congress, a majority of both parties—60 percent of Democrats and 68 percent of Republicans—supported lowering the federal matching percentage.

A clear regional pattern is exhibited by the roll call, with the South voting almost uniformly—excepting the liberal Texan, Senator Ralph Yarborough (D) who changed the direction of his vote in the second session—in favor of lowering the federal matching rate: 93 percent of the southern Democrats wanted to lower the federal matching rate, compared to 43 percent of non-southern Democrats; and 100 percent of southerners Republicans wanted to lower the federal matching rate compared to 52 percent of non-southern Republicans. Comparatively, the Northeast and Midwest was more likely, though less uniformly than the South, to vote to reject any change in the cost sharing formulary. Compared to the near perfect cohesiveness of the southerners rejecting the status quo, only 37 percent of non-southern Democrats and a narrow majority of 52 percent of non-southern Republicans voted to retain the matching formula.

Senator Case (R, N.J.) implied the conflict was regional in nature. Directly addressing Senator Long, Senator Case resented the implications of the reform, that in squaring a state's regular FMAP rate more adversely affected those states that already had the lowest FMAP. "I am tired of having discrimination practiced against a State like New Jersey by measures which, too often, have borne the name of the Senator from Louisiana," (*Ibid.* 27960).

However, the best causal predictor of a senator's preference was his state's FMAP rate (and by extension the state's per capita income). Senator Case implied as much, adding to his critique of the Long Amendment that, "the formula operates inequitably." To highlight his point, Senator Case requested that the adjusted FMAP rates be published in the Record in order to demonstrate how the formula adversely affects certain states, like New Jersey (*Ibid*).

Irrespective of partisanship or region, states with a higher FMAP rate were more likely to vote for the downward revision of the FMAP rate than those states with a relatively higher FMAP rate: for the 2nd session vote, only 22 percent of states with a FMAP rate of 0.55 or below favored revising the matching rate formula, compared to 89 percent of states with an FMAP greater than 0.55.

Further, three-quarters of the votes cast in support of revising the matching formula came that from senators representing states with an FMAP of 55 percent or below can be explained by the state' absence of any Medically Needy program (in Colorado, Hawaii, Indiana, Nevada and Ohio). These states would not have been affected by the reduction in the federal match because the reform only impacted the Medically Needy populations. The small, comparatively wealthy sate of Delaware is an anomalous case, but as it had comparatively low level of per capita spending on Medicaid (particularly spending on what have been the affected medically needy population) any decrease in the state's federal grants-in-aid would have represented an insignificant share of their state's budget.

An improved understanding by the senators of the relative fiscal implications of the amendment may account for the variation in certain senators' votes for the two similar roll calls. Offering support for this perspective, Senator Charles Goodell (R, N.Y.) had criticized his colleagues for bringing up the vote "without warning." "I am convinced that the full implications of this amendment were not understood by all Senators present when it was agreed to," concluded the senator referring to the Senate's vote in 1967. "And

I am certain that many who were unable to be present were unaware that the amendment was to be offered"(Congressional record 90-2 [1968]: 29927).

Of the senators who expressed a preference in both sessions but changed their preference were two Democrats from Wisconsin and a Democrat from each Wyoming and Texas who moved in the "liberal" direction (defined as retaining the status quo), and the Utah and the Indiana Democrats who went in the "conservative" direction (defined as lowering the FMAP rates). Wisconsin and Wyoming had FMAP rates of 0.57 and 0.59, respectively; comparatively, Utah had a relatively high FMAP rate of 0.65. Indiana, despite having a low FMAP rate of 0.53 did not have a medically needy program to consider. Texas, however, had a relatively high FMAP of 0.67 and no Medically Needy program as motivation of Senator Yarborough's anomalous liberal vote.

The McNerney Task Force Recommends 100 Percent Federal Financing of Medicaid

During the 90th Congress, policymakers witnessed total Medicaid payments increase another three-fold to $3.9 billion in fiscal 1968 and then, despite passage of the Social Security Amendments of 1967, to $4.4 billion in fiscal 1969 (respectively, $23.9 billion and $25.6 billion, in constant 2008 dollars). Even after adjusting for general inflation this later trend reflected a 12.8 percent increase in total expenditures, compared to a general inflation rate of 5.5 percent for 1969. This pattern of high medical inflation ensured that even as enrollment growth stagnated after the initial decade, Medicaid budgets continued to increase at

a level greatly exceeding normal inflation.[37] Enrollment reforms alone did nothing to address the seemingly uncontrollable increases in per beneficiary expenditures.

While limiting eligibility to 133⅓ percent of the states' maximum ADC eligibility criteria had certainly restrained the potential maximum growth rate in enrollment, Medicaid expenditures continued to grow tremendously. Even though the Social Security Amendments of 1967 capitated eligibility, millions of poor Americans who were not yet enrolled in Medicaid still had incomes below the new eligibility threshold; and as more states implemented a medically needy program and eligible individuals enrolled and began to use those health care services now available to them, costs increased expectantly. Between 1967 and 1969, the number of Medicaid enrollees jumped by more than a third from 6 to 8.6 million recipients (Senate Committee on Finance 1969). Medicaid enrollments more than doubled again to 17.6 million recipients by 1972. And by 1974 enrollment had surpassed 20 million, a level from which it would not vary by more than a few percentage points over the subsequent decade.

Given such extreme escalation in Medicaid expenditures, Senator Russell Long had evidently been correct to argue that eligibility caps alone would be insufficient to control Medicaid's inflationary spending. By retaining Medicaid's generous cost sharing formula, the states had no short-term incentives to curb their immediate costs by either imposing service restrictions on beneficiaries or extracting any cost-saving concessions from providers. With the states being responsible for as little as a fifth, and in no instance paying any more than half of all expenditures, state public officials would have likely confronted a high political cost for any fractional budget savings that they may have considered advocating. Given the

[37] Of course, the annual increases in per beneficiary expenditures reflected the fact that for much of the past 50 years, medical care-specific inflation has generally exceeded regular inflation by at least 50 percent, and more often than not, significantly more. Medicaid expenditures were particularly prone to health care inflation because prior to 1981 states were required to pay all Medicaid providers on the basis of uniform Medicare "reasonable charges," which were determined by federal officials and largely set by the market (42 C.F.R. § 447.253(c)).

traditionally low public salience of Medicaid, members of congress had little electoral incentive to wage a campaign to reform the technical details of the FMAP formula.

The inability of Congress and the former administration to curb Medicaid's cost curve[38] led the newly elected president, Richard Nixon and his Secretary of HEW, Robert Finch, to commission a Task Force on Medicaid and Related Programs in 1969. The task force was commonly referred to as the "McNerney Task Force" after its co-chairman, Walter McNerney, president of the of the Blue Cross Association. Secretary Finch charged the task force with making recommendations for administrative and legislative reforms that would "deal immediately with the crisis in Medicaid" (Smith and Moore, 2008: 96-117).

It remains beyond the scope of this chapter to fully explore the many policy recommendations included in the Task Force's report to the administration and Congress, but it is worth taking up its commentary as it relates to the financing of Medicaid. In a remarkably progressive recommendation the Task Force largely ignored their mandate to look for cost savings and efficiencies for the federal-state program. Instead, the McNerney Task Force strongly argued for the "establishment of a national policy of

[38] With costs still escalating through 1968 Senator Long had some limited success in 1969. In the 91st Congress Long added a rider to H.R. 5833, a bill that otherwise would have just suspended certain import duties. Offered at the behest of Sen. Clinton Anderson of New Mexico, a state which for a time in 1968 had suspended its purportedly bankrupted Medicaid program, the amendment, as originally designed, would have rescinded the non-discrimination requirement of Title XIX thereby permitting states to cut back some of its Medicaid services. It also would have suspended the requirement that states provide comprehensive care to all Medically Needy by July 1975. A compromise reached by Senator Long and eventually signed into law as P.L. 91-56 prohibited the states that adopted Medicaid programs from reducing cash payments to public assistance recipients (thereby lowering categorically needy eligibility) but permitted them to reduce certain optional medical services available to Medicaid recipients and suspended until July 1977 the comprehensiveness requirement. However, limiting the potential for any reduction in overall costs was the explicit condition that total non-federal spending for medical assistance programs could not be reduced and any plan to control utilization and costs would have to be approved by the Secretary of HEW. Thus, any potential incentives to constrain costs and increase efficiency were limited given it would be reasonable to suspect that providers, whom were a main advocate for Medicaid spending, would prefer to get paid more per patient than see more patients at a lower rate.

financing health care—a policy which treats each of our citizens with equity and justice without regard to the geographical area in which he may live or the ability of a State to participate in the financing of the health care he needs" (U.S. Task Force on Medicaid 1970: 14).

Significantly, the Task Force completely rejected congressional and administrative directions to propose reductions in the Title XIX budget for fiscal year 1971. Its members acknowledged that they could offer no practical solution to the intractable problems of rising medical costs and persistent unmet need of the poor for increased health care services. In fact, just the opposite was their final recommendation.

Despite the already high public costs of the nation's then-current health care delivery system, the panel of experts reflected upon how "assuring access to such care for all who need it will call for fiscal commitments far beyond any that have as yet been made by State and Federal Government" (*Ibid*. 13). The Task Force advised that the increasing fiscal responsibility would necessarily have to fall upon the federal government because the states, with their limited tax bases and inability to raise adequate revenues, "could not be counted on to make up the difference in Federal matching funds." Therefore, as a consequence of the states' more limited resources, "however ingeniously the money is spent, an equivalent savings could not be effected in the short-run." (*Ibid*.13, f.n. 6)

The Task Force did not so much as amend the FMAP but eliminated entirely the cost sharing mechanism fundamental to Medicaid (and the American welfare tradition more generally): their Report recommended, "Converting Medicaid to a program with a uniform minimum level of health benefits financed 100 percent by Federal funds, with a further Federal matching with States for certain types of supplementary benefits and for individuals not covered under the minimum plan" (*Ibid.* 14).

The report represented a more-or-less rejection of the cooperative federalism framework that had The task force prefaced their report with the apt observation: "one man's pluralism is another man's incoherence." (1970: 3)

Overall, the Task Force's report was an astonishingly progressive document that in many ways resembled provisions included in the Democrat's health reforms passed 40 years later as part of the Patient Protections and Affordable Car Act of 2010, including the notion of a federally-defined essential health benefits package and a uniform extension of Medicaid eligibility. With respect to Medicaid eligibility, the Task Force described the standards defined by the Social Security Act of 1967 as "arbitrary." Relative to the Nixon administration's concurrent Family Assistance Plan proposal that guaranteed an annual income of $1600 for a family of four, many states' low Medicaid eligibility thresholds "created an illogical situation in which persons are assumed to need maintenance assistance but not medical assistance." Instead, the Task Force recommended that Medicaid "extend coverage to additional groups until, as a minimum, all persons at or below the poverty level are eligible" (U.S. Task Force on Medicaid 1970: 15). Comparatively, the Affordable Care Act of 2010 mandated Medicaid coverage for individuals with household income up to 133 percent of the federal poverty line. Further, the 100 percent federal matching recommended by the Task Force was incorporated into the 2010 law; although in the case of the latter legislation the rate applied only to newly eligible beneficiaries and the federal matching would drop, marginally, to 90 percent by 2020.

Concerned as Congress was about the federal Medicaid budget, Congress saw the Task Force's recommendation as a non-starter and never took up debate on the proposal to shift a 100 percent of most Medicaid costs to the federal government. As Smith and Moore concluded their assessment of the recommendations of the McKerney Task Force, "It is an instructive paradox that one of the few valuable proposals for restructuring Medicaid came from a Republican administration that because of divided

government and the political temper of the times, the Democratic Congress was not interested" (Smith and Moore 2008: 99-100).

Medicaid and Medical Inflation in the 1970s

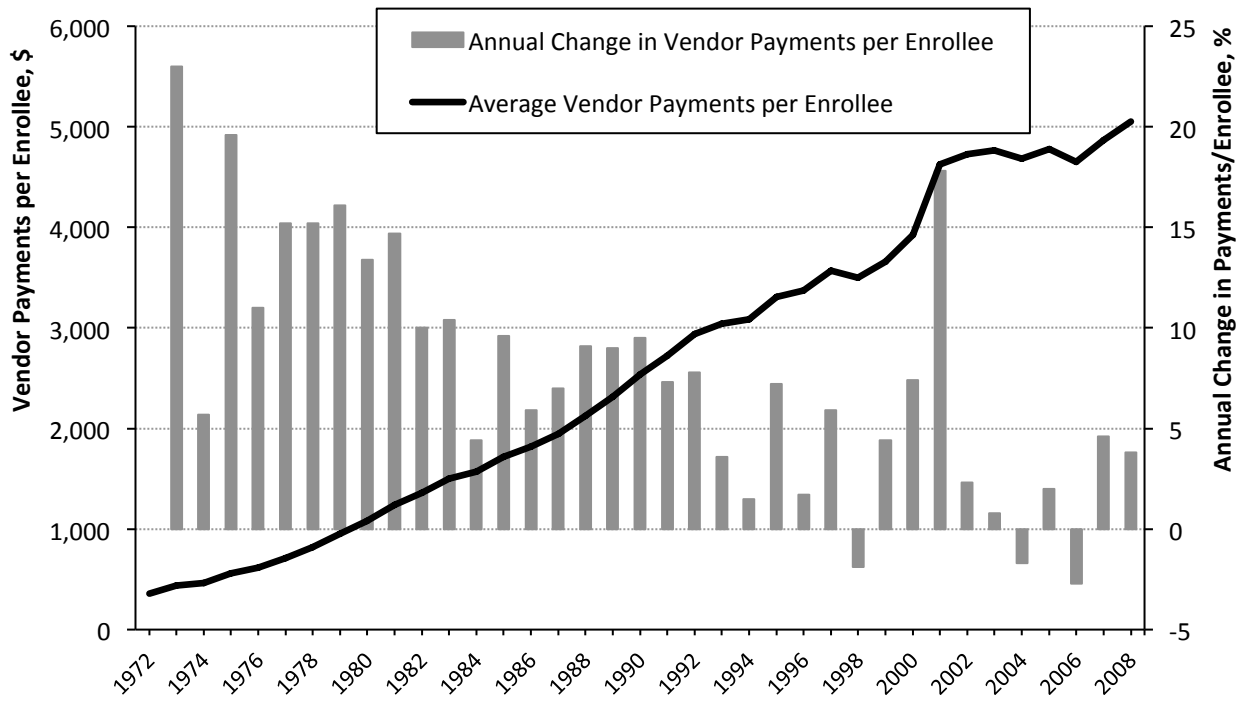
In 1971, the then-Governor of California, Ronald Reagan warned his fellow Californians that "the whole welfare system is about to collapse from the financial burden [Medi-Cal] is putting on the taxpayers" (Reagan 1971). With Medicaid spending outpacing budgetary projections across the nation, Governor Reagan's critique was representative of more general anxieties over Medicaid's sustainability. The growth rate of Medicaid budgets was giving state policymakers legitimate concerns that their commitments to the poor would require the state to raise marginal tax rates and/or reprioritize their public commitments.

Yet, despite Governor Reagan's concern over the tax burden that Medi-Cal was imposing on Californians or, for the matter, the McKerney Task Force's more general fear that the states were incapable of continuing to finance the increasing costs demanded by Medicaid, for the duration of the Seventies neither Congress nor the administration was much interested in offering a solution to Medicaid's cost crisis.

Between 1971 and 1980, Medicaid's total costs rose from $3.9 billion to $26.4 billion, adjusted for 2008-dollars, 570 percent increase in expenditures. During that same period the number enrollees increased from 18 million to 21.6 million, just a 20 percent increase in the number of enrollees over that same period. Even after enrollments first stagnated during the mid 1970s and then declined during the later part of the decade, by an average of 0.7 percent annually between 1977 and 1981, costs continued to increase precipitously. **Figure 3.4** looks at the increase in average per beneficiary expenditures over Medicaid's history; the solid bars indicate the annual real growth rate of total Medicaid expenditures

adjusted for regular inflation illustrate (the percentages in the figure reflect the increase over and above growth in the Consumer Price Index). Even during the late 1970s when sharp increases in inflation impacted the national economy and contributed to even higher increases in medical costs, Medicaid expenditures increased at yet an even greater pace, exceeding general inflation by 5 percentage points during the later part of the decade.

Figure 3.4. Average Medicaid Spending per Beneficiary (based on Annual Unduplicated Enrollment), FY1972-2008



The 1970s, in particular the later half of the decade when state revenues declined relative to federal revenues, witnessed a considerable broadening in the gap between what the federal and state governments' committed as a share of their revenues to Medicaid. Over the decade, average total spending on Medicaid as a share of the state's total general revenues (i.e. including federal transfers payments) more than doubled from 5.2 percent in 1971 to 10.7 percent in 1980. The state-share of Medicaid measured as a share the states' own-source general revenues (i.e. excluding federal transfer payments) increased from 3.4 percent

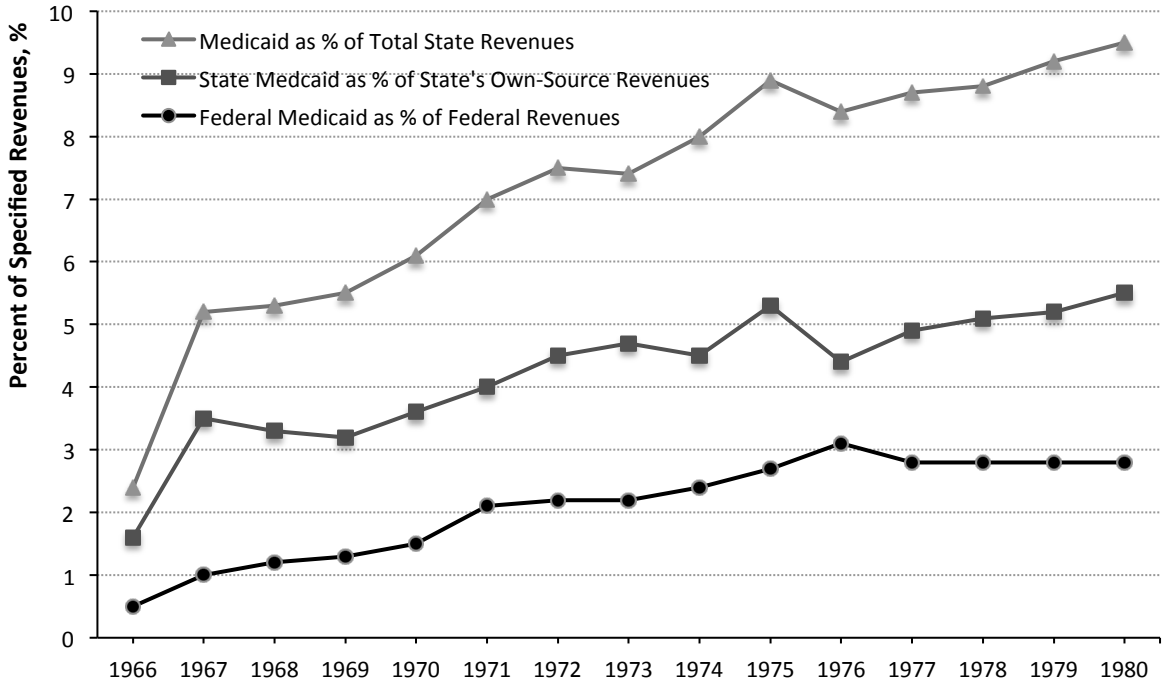
to 6.5 percent. Comparatively, while federal Medicaid costs also increased, the federal government's revenues also rose. As a result, the federal share went from 2.1 percent to 2.8 percent of federal general revenues over that decade; and for the last six years of the decade—despite it being a period of extremely high inflation—the share of federal transfers for Medicaid remained steady at about 2.8 percent.

Figure 3.5 charts the national average budgetary commitment to Medicaid in the fifty states between 1966 and 1980. The figure shows the average percentage of general revenues consumed by total Medicaid spending and, separately, the average percentage of the state's own source resources (i.e. exclusive of federal transfer payments, but inclusive of local government transfers) and the average percentage of combined state and local general own resources that are used to finance the state's share of Medicaid/CHIP spending. Over the subsequent three decades, concerns over the sustainability of Medicaid would only worsen, particularly as the fiscal burden imposed by Medicaid's ever-increasing costs disproportionately affected the individual states that had more limited revenue sources and therefore lacked the revenue raising abilities of the federal government.

More than concern over the rise in the absolute expenditures on Medicaid, it was this increase in the states' proportionate share of total revenues that legitimated many policymakers' concerns over Medicaid's fiscal sustainability. As such, it is difficult to give an overall assessment of Medicaid's first decade and a half. From an enrollment perspective, it was a significant success: whereas all efforts prior to 1965 to enroll needy Americans in health insurance failed to achieve the enrollment objectives set for those programs, Medicaid was a resounding success in enrolling millions of Americans and getting these individuals the care many of them so desperately needed. However, from a budgetary perspective, the very success of Medicaid in enrolling the poor, coupled with the high cost of providing comprehensive coverage to each enrollee, meant expenditures that consistently exceeded projections were becoming untenable for states with limited resources. Still as unanticipated and seemingly unsustainable as Medicaid's high costs

may have appeared after its first decade and a half, these costs would come to appear moderate in hindsight of Medicaid's subsequent development.

Figure 3.5. Medicaid Spending as Share of Government Revenues, variously measured, FY1966-1980



Chapter 4

The Rising Taxpayer Burden of Medicaid

This chapter and the following chapter consider the three decades of policy development between 1980 and 2010. Section III of this Dissertation examines this 30-year period from a quantitative perspective. Chapter 4 begins with a look at the Omnibus Reconciliation Act of 1981, introduced by the Reagan administration, that included a proposal to block grant Medicaid and limit the federal government's fiscal liability for the program in return for giving the states greater latitude in defining eligibility and benefits. While his "Medigrant" proposal could not achieve majority support, congressional Republicans managed to overcome opposition to enact a temporary reduction to Medicaid's federal matching rate. The experiment in reducing the federal government proportional contribution to Medicaid highlighted the sensitivity of the state's Medicaid programs to the federal government's contribution: during the three years in which the OBRA reduced the states' federal share by a few percentage points, the nation's Medicaid spending patterns changed abruptly with overall expenditures stagnating for the first time and following a prolonged period of double digit inflation.

However, the 1981-84 period would prove to be an aberration. Following the sunset of the OBRA '81 reductions to Medicaid's federal match, Medicaid experienced renewed inflation. **Figure 4.1** charts the significant increase in total Medicaid spending, nominal and real (adjusted for 2008 dollars), between 1980 and 2008.

The desire by Congress and, for the most part, the willingness of the states to expand access to adequate health care for their poor population increasingly collided with the need of states to balance their

budgets. As Medicaid eligibility and benefit costs continued to increase faster than the ability of the states to raise revenues, the share of state budgets committed to the health care needs of poor residents rose and imposed increasingly burdensome fiscal pressure on public officials. **Figure 4.2** presents the individual state-level data on Medicaid spending as share of state revenues between 1980 and 2009. In both **Figure 4.1** and **Figure 4.2**, the periods, 1990-91 and 2000-01, are clear inflection points in the fiscal history of Medicaid.

Figure 4.1. Total Medicaid Spending, Nominal and Real, FY1980-2010

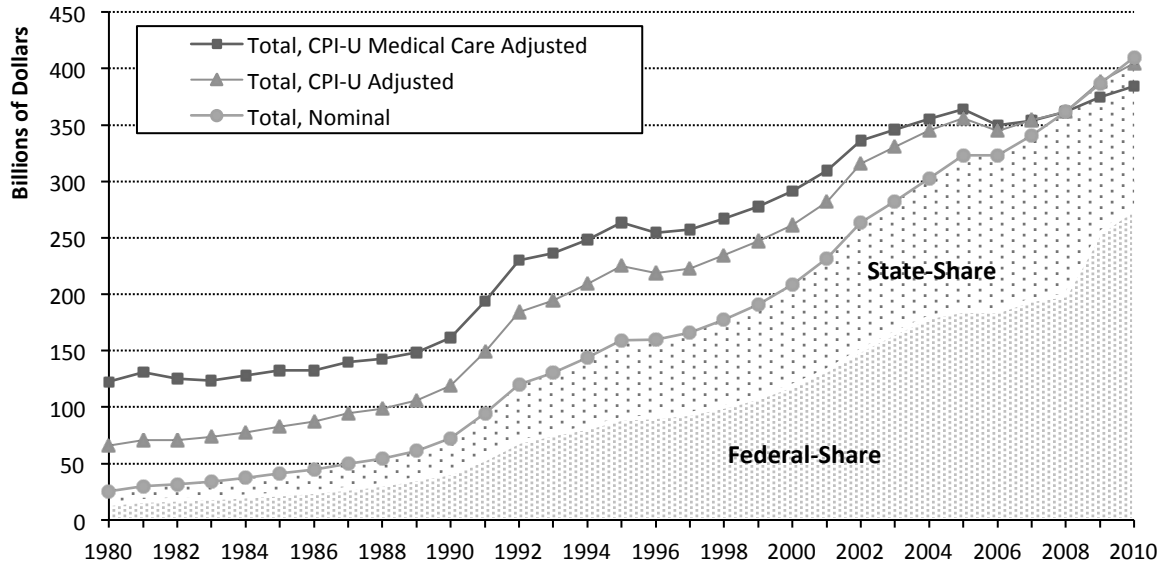
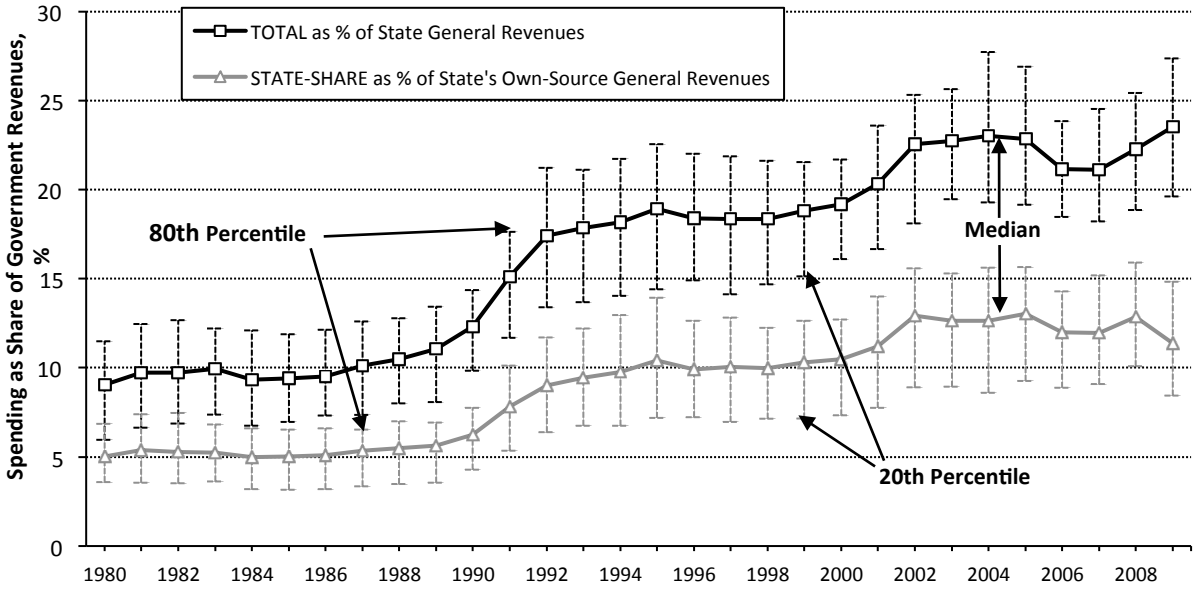


Figure 4.2 Total and State-Share of Medicaid Spending as Share of Government Revenues, by State, FY1980-2009



Sources: 1980-2006, data request from CMS; 2008 and 2009 from statehealthfacts.org

The imbalance between revenues and expenditures led to efforts by policymakers and administrators to recast the calculus of Medicaid's cost sharing formula. The chapter explores proposals introduced by Senator Patrick Moynihan to adjust the formula to better reflect the states' variable ability to pay for Medicaid services relative to the variable need for such services, as well as recommendations offered by the Government Accounting Office to employ better data in establishing what was a proper distribution of fiscal responsibilities for the states' own Medicaid commitments.

The final section of the chapter considers the eligibility initiatives enacted by Congress to incrementally expand access for the nonelderly poor—particularly pregnant women, infants and uninsured children. Without the implementation of any credible solution for adequately controlling the public's fiscal burden and reigning in the state's exposure to Medicaid-related inflation these eligibility reforms exasperated the rise in Medicaid expenditures beginning in the second half of the 1980s.

President Reagan Attempts to Reform Medicaid

Omnibus Reconciliation Act of 1981: Reagan Proposes to Block Grant Medicaid

As governor, Ronald Reagan had considerable success in controlling the California's exposure to the rising costs of Medi-Cal in the first half of the Seventies. By reducing reimbursement rates and imposing a greater responsibility on local governments for the health care needs of their residents the state was able to slow the growth in its Medicaid program relative to other states (Sparer 1998). As a result, California's share of its Medicaid program required only 3.9 percent of the state's own-source revenues in 1980—less than half of the national average. Significantly, California was able to keep its per capita costs low despite

maintaining expansive coverage equivalent to 133% of those living below the federal poverty line, the second highest rate among in the nation.[39]

No doubt motivated by the example he set during his governorship; upon assuming the presidency in 1981 Ronald Reagan included reforming Medicaid as part of his ambitious domestic agenda. Specifically, he sought to contain federal expenditures by granting the states greater flexibility in administering their Medicaid program. President Reagan believed if it were required of them governors and state legislators would be more capable of controlling costs than the Washington bureaucracy—as his tenure in California had demonstrated was possible.

To that end, an early component to President Reagan's New Federalism agenda was a proposal to cap the federal government's Medicaid expenditures and to more fully devolve the responsibility of providing means-tested medical assistance to the states. The federal government would establish a maximum federal outlay for the states, in return grant the states discretion to amend or curtail Medicaid eligibility and services with a minimal federal oversight in order to maintain a budget. The administration anticipated that by limiting Federal spending, States would have additional incentives to provide cost-effective services and to reduce fraud, abuse, and waste.

In the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) the president and his administration advocated for capping federal Medicaid payments. As part of a larger deficit reduction package, these so-called block grants would have reduced the federal government's current fiscal year's cost

[39] Critics, however, argue some of the savings may have been more illusionary than real because the state figures do not capture the additional health care-related burden imposed on the county governments who are mandated by state law to be the providers of last resort for low-income uninsured people ineligible for coverage through other public programs. Los Angeles County, for example, experienced an eightfold increase in its health care costs over the decade following the Governor Reagan's reforms eliminated local medical-cost pass-through and capped state responsibility (Lee and Ensminger 1981; Sparer 1998).

sharing by $100 million and, thereafter, impose a limit, or cap, its appropriations. For fiscal 1982, the federal cap would be equal to 105 percent of the federal outlays of the previous fiscal year. The cap for each following year would increase according to the prior year's inflation, as measured by the GDP deflator.

A report prepared by the nonpartisan Congressional Budget Office (CBO) estimated that if Congress adopted President Reagan's proposal to cap federal program expenditures the federal government could expect savings of $1 billion in fiscal 1982 and up to $5 billion a year by 1986 compared to the status quo law. This reflected nearly a 20 percent savings over the CBO's baseline estimate that federal costs would reach $24 billion by 1986 if Congress did nothing to reform Medicaid (CBO 1981)

Although cautious to not directly discredit the status quo, the CBO prefaced its report with the observation that "the magnitude of Medicaid expenditures has reached what many legislators consider to be critical levels" (CBO 1981: ix). Yet despite the apparent urgency to contain Medicaid costs, neither the administration's preferred policy of imposing a federal cap on Medicaid appropriations nor the Democrats' own competing proposal to temporarily reduce federal outlays between 1982 and 1984 could get enough votes in the Democrat-controlled House's Energy and Commerce Committee and so the solution was left, rather uncharacteristically, to be decided by the full chamber.

Representative Henry Waxman (D, Cal.), who as chairman of the Health and Environment Subcommittee would become one of the most influential policymakers with respect to Medicaid for the next three decades, criticized President Reagan's proposal for being needlessly ideological and inherently irresponsible. "A cap on Federal Medicaid contribution does nothing to address the underlying problems of health care cost inflation or inappropriate utilization," argued Representative Waxman. "It does not stop hospital costs form rising. It does not cap the aging process. It does not change people's basic need for medical care. All a cap will do is shift the cost from the Federal Government to the States."

With Medicaid expenditures having increased at an average rate of more than 15 percent per year over the previous 5 years, more than twice the rate of general inflation, the states' governments had legitimate reason to be concerned that their Medicaid expenditures would increase at a much greater pace than would the Medicaid budgets appropriated to them by Congress. Specifically, with Medicaid costs estimated to rise about 18 percent over fiscal 1981, governors were cautious to accept only a 5 percent increase and assumption of any fiscal liability above the federal capitation. In an op-ed published in *The Washington Post*, Governor Bruce Babbitt (D, Ga.), the influential chairman of the National Governors Association, labeled the block grant as "unacceptable" and characterized it as "a tactical weapon to cut federal budgets while deputizing the governors to hand out the bad news." The proposal was a maneuver to "repeal the Great Society and remake the federal system" (Babbitt 1981).

Despite an intensive lobbying effort by President Reagan, the administration was never able to win over the governors' support. The *Washington Post* reported that Republican and Democratic sources said that with respect to the reconciliation process the "hottest lobbying came on Medicaid, on which a number of governors as well as hospital groups exerted pressure on delegations" (Rich and Omang 1981). The support of governors was particularly critical because they were "the only people in town who support the block grants" in principle. According to an official at the National Governors Association, "If [the governors] don't go along with Reagan's proposals, Reagan will have a harder time convincing Congress to support them" (Weisman 1981: B8).

A compromise amendment introduced by Representative James Broyhill's (R, N.C.) raised the proposed annual increase of the federal cap 50 percent, from 5 to a 7.5 percentage points. However, while a majority in the Democrat-controlled House tentatively accepted this compromise, the administration saw a vote on the amendment as "too risky" and worried that such a vote would endanger the entire budget bill. In the end, the administration failed to convince critical policymakers of the efficacy of its block grant

proposal. As a rebuttal to the administration a loose coalition of Republican House members from the Midwest and Northeast sent a letter to the president's budget director, David Stockman, indicating they "found a cap on Federal Medicaid expenditures to be unacceptable" and opposed "the use of the reconciliation process to enact block grants" (Rich and Omang 1981). Reporting on the "pandemonium" on the House floor, the *Washington Post* described how just minutes before the final vote and to the "astonishment" of many, Representative Broyhill rescinded his amendment, effectively concluding any further consideration of the block grant proposal (*Ibid*).

While it was not voted upon, Representative Clarence Brown, a Republican from Ohio, introduced his own bill (H.R 3756) as an alternative to the administration's proposal that is worth consideration (see *Congressional Record* 127 [1981]: 11233-34). Representative Brown supported the idea of capping Medicaid payments to the states, accepting that the fiscal discipline imposed by the federal cap was "both necessary and practical"; however, in recognizing the countercyclical nature of Medicaid expenditures, he proposed a variable Adjusted Federal Medicaid Assistance Percentage ("AFMAP") to help hard-hit states. The AFMAP formula took into consideration a state's unemployment rate and cost of living, relative to the national averages, when appropriating the states' federal share.

Mr. Brown explained, "Using per capita income alone to allocate federal Medicaid funds to the states misrepresents the fiscal capacities of states in the Northeast, Midwest, and other regions which have been adversely affected by downturns in the economy, while it understates the fiscal capacity of several oil and mineral-rich states" (Blade Washington Bureau, 1981).

To achieve a more equitable allocation of federal resources, Brown's formula involved a three-step process for determining each state's adjusted block grant.

First, a state's FMAP is adjusted upward if the state has a high cost of living or high unemployment rate. If either or both of these state-level economic indicators are higher than the national value then the ratio of the state's cost-of-living or unemployment rate to the respective national economic indicator is multiplied by five percentage points with the result then added to the state's base FMAP. There would be no downward revision of a state's FMAP for states having a lower cost of living or unemployment rate.

Second, the adjusted FMAP is multiplied by the state's total Medicaid spending for fiscal 1981 (inclusive of the federal and state shares) to get the amount of federal monies that the state *would* have received in 1981 given this adjusted FMAP. Summing every state's adjusted federal share provides a new hypothetical amount for the federal government's total Medicaid budget for 1981. A state's adjusted federal share would then be divided by the *total* adjusted federal share to get that state's adjusted percentage share of the federal Medicaid appropriation.

Third, to get the actual appropriation level available to each state, a state's adjusted percentage share is multiplied by the total federal Medicaid appropriation authorized by federal statute.

Representative Brown acknowledged that in contrast to the administration's proposal his adjusted redistribution of funds benefited slightly less than half of the states—meaning more than half would see their federal share drop modestly relative to the administration's proposal. However, the states benefitting would change with the relative economic conditions of the states. Regardless, the Brown formula would have only redistributed just 2.1 percent of the aggregate federal amount proposed by the Reagan administration in 1982: approximately $360 million of the $17 billion federal cap. While he acknowledged that his state of Ohio, with above average unemployment in 1981, would be a bit better off with the adjusted formula (on the other hand, Ohio's cost of living was below the national cost of living and so the state saw no adjustment for that component). But, as local economies waxed and waned across the nation it

could be expected that Ohio would not always benefit from such an adjustment. Given the variability of the identified economic indicators and the real impact that they have on Medicaid expenditures, Representative Brown believed such redistribution was justified, summarizing, "it is only fair that the formula by which these [finite] funds are distributed be adjusted to reflect changes in State fiscal capacities."

While Representative Brown's bill to amend Title XIX was not taken up after being referred to the House's Committee on Energy and Commerce it was taken up in hearing. The formula that he advocated represented a novel approach to reforming Medicaid financing. Alternatives to the FMAP would proliferate over the following decades and some of these would incorporate additional economic indicators while others would revive efforts for a hard federal capitation, but few would combine the fiscal discipline of a fixed global budget with the variability of local payments in the robust manner advocated by Representative Brown in 1981.

Instead of ending the open-ended entitlement as the president had originally proposed, the House accepted the Democrats' alternative plan introduced by Representative John Dingell (D, Mich.). The Dingell amendment was a temporary, across-the-board reduction in the federal share appropriated to the states that allowed the federal government to still meets its short-term deficit reduction goals. The proposal reduced transfer payments by 3 percent in 1982, 4 percent in 1983 and 4.5 percent in 1984. These annual reductions, however, could be curtailed by 1 percentage point for each of the following reasons: instituting a qualified hospital cost review program; if the state had a high unemployment rate (defined as 150 percent of national average) for the quarter; if third party and fraud abuse recoveries for the previous quarter are equivalent to 1 percent of federal payments to the state. In 1985 the open entitlement would revert to its normal funding. Of course, the temporary cuts did nothing to fundamentally affect the FMAP formula, as had been the administrations intent.

With Democrats controlling the House 242 to 190, President's Reagan's Omnibus Budget Reconciliation Act of 1981 was just narrowly passed 216 to 212. The Act embodied nearly the administration's entire package of preferred cuts, excepting the federal cap to Medicaid. A colleague described the substitute amendment as a "well thought out approach to cutting expenditures in the Medicaid program" (*Congressional Record* 127 [1981]: 14642).

In the Republican-controlled Senate, the administration would have greater success, at least initially. In the Senate, the federal cap would become part of the Senate's version of the budget bill, albeit with the annual increase in the federal cap raised from 5 percent to 9 percent. The Senate's bill also reduced the minimum federal share from 50 percent to 40 percent.

This latter reform would have had significant implications for the nation's comparatively wealthy states. For example, California, Illinois, and Michigan, three states that alone account for a quarter of all federal Medicaid grants, would have seen their federal matching rate drop by an average of about 15 percent, from 50 percent to 41.79, 42.59 and 47.69, respectively (CBO 1981: 55). The reduction would have affected 13 states' FMAP rate for fiscal years 1982-83. Further, an additional 10 states skirted within 5 percentage points of the 50 percent floor and so would have reason to fear that they could be potentially affected in the near future.

The relative success of the administration in the Senate could be in part attributed to the legislative rules of the reconciliation process that expedites legislation under a more limited set of procedural rules. In contrast to how minorities of senators threatened a filibuster to thwart Senator Long's attempts in 1968 and 1969 to lower the FMAP formula, the reconciliation processes inhibits such brinksmanship. Whereas in the House a majority of representatives were elected in states with lower FMAPs and so could persuasively

threaten to derail legislation, in the anti-majoritarian Senate such senators did not represent a majority of the states and so had less ability to influence policy.

Nonetheless, a late floor discussion led by the Chairman of the Senate Finance Committee, Senator Bob Dole (R, Kan.), was intended to mollify the concerns of many of his colleagues who sat across the aisle and were critical of the bill (for example, see floor statements by Max Baucus and Daniel P. Moynihan who characterized the proposals as a shortsighted prioritization of crude cost savings over genuine programmatic reform; at *Congressional Record* 127: S6121, S6122). Before the Senate vote on the bill, Senator Dole pledged that he would not advocate for the retention of the federal cap or FMAP-related provisions during the conference committee negotiations that would be necessary to resolve differences between the two chambers' competing reconciliation bills.[40] He explained that the short-term retention of the provisions in the Senate bill was simply an expedient decision to avoid an extra vote in the chamber. He assured his colleagues, Republicans and Democrats, alike, that he would "remove most of the concerns in conference" (*Congressional Record* 127(9-11): 13914). Senator Bill Bradley (D, N.J.) who voted for the Senate's bill only "after Senator Bob Dole gave me his word to help" to preserve the House's language explained that as a consequence of Senator Dole's willingness to accept the House's more limited cuts, "New Jersey, instead of losing $80 million, suffers only a $10 million loss, and insures that poor people still have access to health care" (*Congressional Record* 127: 19097).

[40] The Conference Committee included an unprecedented 259 congresspersons from the Republican-controlled Senate bill and the Democratic-controlled House who met in July to resolve differences between their respective versions of OBRA 1981. The administration's budget director David A. Stockman lobbied the Senate to bypass the Conference altogether and just accept the House version of the bill without any changes. While only $800 million separating the two bills—with the Senate's total budget savings of $38.1 billion slightly larger than the House's $37.3 billion—one of the major sticking points was over cutbacks in Medicaid and various health program that the House had capped. (Houston 1981)

In addition to accepting the House's more modest cuts, Senator Dole proposed the creation of a presidential commission mandated to confront Medicaid's fiscal crisis. The commission would evaluate various cost savings proposals, including the administration's block grant proposal, and submit policy recommendations to Congress and the administration for later consideration. Such a mandate would be meaningless if the hastily debated reforms were enacted before the commission could have its inaugural meeting and offer its own recommendations. It is likely that Senator Dole believed the commission would legitimate the Republicans' sweeping reform to Medicaid and give conservative leaders the necessary leverage to overcome the entrenched opposition on the Left and among governors and providers groups.

"We believe that we could satisfy the concerns of some of the Governors in about 30 states, and probably all the states, with the establishment of this Federal commission," said Senator Dole, presumably a reference to the National Governors Association recently voiced opposition to any federal capitation of Medicaid transfers (*Congressional Record* 127(9-11): 13913).

The proposed commission seemed to also satisfy some Democrats: Senator Nunn (D, Ga.) told his fellow Democrats that the commission would allow the governors to "be able to monitor these large cutbacks that are going to take place in the Medicaid program"; and, Senator John C. Stennis (D, Miss), who added himself as a cosponsor, saw the commission as necessary because he was convinced that Medicaid "is not going to be on a sound basis until something in depth is learned about all the facts and a new start taken" (Ibid).

Senator Dole's assurances to his colleagues were met when the conference committee retained the Houses' provisions as they related to Medicaid, including its temporary reduction in federal outlays in lieu of either the federal capitation or any lowering of the minimum FMAP rate. Representative Dingell called

the preservation of Medicaid entitlement as "perhaps, the greatest achievement of the conference [committee]" (Congressional Record Vol. 127: 18957).

The Conference Report kept the House's instruction for the nonpartisan Government Accounting Office to "study the Medicaid formula and provide information that would contribute to a more equitable distribution of Federal Medicaid funds to States," instead of a more expansive (and more partisan) presidential commission, as proposed by Senator Dole. The GAO's instructions, limited as they were to studying the FMAP, removed any assessment of a potential Medicaid block grant from their prospectus (Pub. L. No. 97-35, § 2165, Stat. 357, 806; *Congressional Record* 127: 18548).

In cutting federal outlays by $130 billion over three years (equivalent to about $280 billion in cuts in 2008), 1981 represented the then largest historical cut in peacetime federal domestic spending and was a significant early achievement for President Reagan's agenda. The conversion of Medicaid from an open-ended entitlement into a block grant was one victory Congress denied the president, however.[41]

[41] Given its importance to Medicaid's overall expenditures it also worth mentioning the inclusion of an extension of the so-called Boren Amendment in OBRA '81. Having first been enacted in 1980 with respect to nursing homes, this reform repealed the Medicaid law requiring that states pay for inpatient hospital services at the Medicare's "reasonable charges" rate. Instead, the Boren Amendment instructed the states to use a rate that was merely "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards" (Section 1902(a)(13) of the Social Security Act). Expecting that this statutory allowance for increased state discretion would result in lower Medicaid payments for many hospitals, especially those serving a large number of Medicaid and uninsured patients, Congress included a provision specifying that a state's reimbursement rates had to take into account whether hospitals serve a "disproportionate share" of low-income people. Any facility designated as a disproportionate share hospitals (DSH) were to be provided with supplementary payments that would be matched according to the state's regular FMAP rate.

While it would be at least a decade before states learned how to leverage DSH payments to augment their Medicaid budgets, this provision would eventually have significant ramifications for the Treasury. As more states got involved and federal funding for DSH significantly increased in the late 1980s and early 1990s Congress began passing legislation to limit DSH funding increases. Significant changes to DSH were passed in 1991, 1993, 1997, 2000, and 2003. (Several of the more recent acts restored some of the cuts in DSH payments to states.)

The Medicaid-AFDC/Food Stamp Swap: President Reagan Proposes Fully Federalizing Medicaid

Having failed to cap the federal government's contribution to the states for Medicaid in 1981 and with no potential of an mandated commission's report to trumpet the benefits of a Medicaid block grant, President Reagan tried a different approach to reforming Medicaid and upending what was still perceived by most to be the unsustainable status quo. In his State of the Union of 1982, the president proposed to Congress that the federal government should fully finance Medicaid itself. In exchange for the federal government assuming full fiscal responsibility for the nation's Medicaid liabilities the states would be responsible for financing the two major income support programs, AFDC and food stamp. The "swap" as this exchange was referred would commence in fiscal year 1984.

Lynn Etheredge, a veteran of the OMB's health policy branch, explained how the Reagan administration "confounded nearly everyone by reversing course on Medicaid." She added, "The flip-flop was all the more puzzling since both the Nixon and Ford administrations aimed to avoid a federal Medicaid takeover at all costs in the belief that a federal Medicare program and a federal Medicaid program would inevitably lead to a nationalized health system" (Etheredge 1983: 19).

At the time, without knowing the full details of the administration's proposal, the CBO crudely estimated that the federal government would see a net savings of $1.5 billion in fiscal year 1984 and almost $5 billion over its first 4 year. However, another report concurrently released by the GAO, highlighted how the different growth rates for the three programs made forecasting unreliable and long-term estimates of relative savings difficult. In contrast to the CBO's projection for cost savings, the GAO warned that the

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Additionally, the Boren Amendment led to a spate of lawsuits alleging payments were neither reasonable nor adequate. Consequently, many states did not lower payments schedules, possibly to avoid legal challenges from medical societies and nursing home groups. Congress repealed the Boren amendment in 1997.

swap could be potentially ruinous for the federal treasury, noting that while the respective per recipient costs for AFDC and food stamps had increased by an annual average of 5.1 percent and 5.9 percent over the past 5 previously years (1977-81), for Medicaid that rate was 12.1 percent over the same period (CBO 1982, GAO 1982). The GAO was rightfully concerned that if Medicaid's rate of inflation continued, Medicaid would soon eclipse, and significantly so, the combined cost of the other two welfare programs.

Experience proved the GAO's concerns to be prudent: total spending on Medicaid/CHIP currently stands at approximately ten times the aggregate amount spent by the states and federal government on Supplemental Nutritional Assistance Program (the former food stamps programs) and Temporary Assistance For Needy Families (formerly, AFDC). Of course, the hypothetical counterfactual is that had the federal government been successful in assuming full responsibility for Medicaid's financing it would have also acquired the ability to effectuate additional reforms that could have better controlled aggregate Medicaid spending.[42]

Although the governors were likely to later rue not fully supporting the opportunity to rid themselves of Medicaid's fiscal burden, the states and members of Congress were hesitant to back the "swap" for such uncertain gain. No one but Reagan and his staffers seemed very enthusiastic about the

[42] For example, it is likely that there would have been less abuse of DSH payments in the early Nineties had the payments been subject to greater federal scrutiny. Conversely, however, without state balance budget laws imposing a modicum of restraint on Medicaid budgets, federal expenditures could have actually increased relative to the status quo. For example, section 1902(a)(13) of the Affordable Care Act requires states to increase their Medicaid reimbursement rates for certain primary care physicians to Medicare levels, with the federal government providing a 100 federal match for the cost differential between the two payment rates. This provision alone is expected to cost the federal Treasury $5.74 billion in 2013 and $5.96 in 2014 (*Federal Register* Vol. 77, No 92: pp. 27671-27691, (Friday, May 11, 2012)).

reform, and so within weeks of the introduction of Reagan's dramatic proposal, the swap silently died without ever being taken up in Congress.[43]

The Balanced Budget Act of 1995 and the Republican's Medigrant Proposals

In 1995, the Republicans under the leadership of House Speaker Newt Gingrich (R, Ga.) gained control of both chambers for the first time since 1952 and interpreted the midterm as a mandate to implement their Contract with America and reform government. Having defeated the attempted health reform legislation pursued by President Bill Clinton and First Lady Hilary Clinton during the previous Congress, the Republicans' agenda included their own proposal to reform the federal government's relationship to health care. To that end, the Republicans included in their Omnibus Balanced Budget Act of 1995 (H.R. 2491) the Medicaid Transformation Act. Similar to Reagan's proposal 25 years earlier, this bill repealed Medicaid's entitlement status and converted the open-ended federal match for state Medicaid expenditures into a block grant program called "Medigrant." The reform was expected to slow the annual growth in federal spending on health care, thereby saving the federal government $163 billion over the next seven years (CBO 1996).

The Medigrant plan was similar to President Reagan's earlier block grant proposal that had passed the Senate in 1981; however, it differed from Reagan's plan in two significant ways. First, instead of uniformly increasing in the federal cap for Medicaid expenditures, the Medigrant legislation borrowed some ideas from the alternative Brown formula introduced in 1981 as an amendment to OBRA '81 (see above).

[43] The only Medicaid-related legislation to pass in Congress that year was included in the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) that revised Medicaid cost sharing policies between the states and recipients by allowing for the expansion of state options for imposing nominal cost sharing on certain Medicaid beneficiaries and services.

Under the Republican's Medigrant proposal, a state's appropriation would be determined by a state's historical Medicaid spending (for 1994) adjusted for certain "needs-based" factors: including national health spending per poor person, adjusted for local costs, the demographics of the state's Medicaid population, and the number of residents in poverty, (Lambrew 2005: 6). Despite the well-defined nature of the formula, the Secretary of Health and Human Services, Donna E. Shalala, criticized the aggregate cap on state allotments as an essentially as arbitrary limit driven by federal budgetary concerns. Despite the supposed attention to needs-based factors, she explained the simple fact was, "the states' allotments are determined through the use of 'floors' and 'ceilings', rather than by the results of the need-based formula" (Committee on Finance 1996: 132).[44]

Second, the Medigrants were accompanied by an upward revision of the FMAP formula. As passed by Congress, the legislation allowed states the choice between three alternative FMAPS: (1) their current rate; (2) the lesser of a new formula based on state's Aggregate Expenditure Need (a function of the number of residents in poverty, a case mix index, national average spending per poor adjusted for local health care costs) and Total Taxable Resources or the current law plus 10 percentage points; or, (3) a federal share of 60 percent. Every state would see an increase in its federal matching rate, with the wealthiest states seeing the largest increase of 25 percent, from the current minimum of 50 percent to 60 percent (most administrative expenditures would remain reimbursed at 50 percent across the nation). The maximum rate would remain 83 percent (Section 2122 of H.R. 2491).

Up to a state's maximum allotment, health costs would be shared between the states and federal government according to each state's revised FMAP; however, beyond each state's allotted federal share, the state's federal match would drop to zero and the state would be fully liable for any additional spending.

[44] This assessment was made in relationship to the Republican's subsequent 1996 proposal, S. 1795, a bill that made only marginal changes to the Medigrant proposal vetoed by President Clinton in 1995.

The upward revision of the states' federal matching rates meant that the states could maximize their federal share with fewer state resources than they would have to if the Medigrants was implemented without any concurrent change to the FMAP—as much as 20 percent less in certain states. Quickening the attainment of the federal cap and zeroing the federal match once attained, however, would lessen the states incentives to maintain their current fiscal commitments because their marginal cost for a portion of previously subsidized state spending will have significantly increased.

The Republicans in Congress believed they were justified to encourage an overall decline in both state and federal spending on Medicaid. At the federal level, Speaker Gingrich saw controlling Medicaid spending as a perquisite to achieving and sustaining a balanced budget. And with respect to the states, federal Republicans defended capitation as being necessary to suspend the crowding out effect that Medicaid had on state budgets. "As state Medicaid spending has experienced uncontrollable rates of growth, other critical State funding initiatives have suffered commensurately," critiqued the Conference Report, citing data from the National Association of State Budget Officers. For example, between 1987 and 1994, as a share of total state expenditures, elementary and secondary education spending dropped 11 percent, state higher education spending fell 8 percent, other welfare-related spending decreased 13 percent, and public transportation investment declined 16 percent. Meanwhile, Medicaid spending increased over 90 percent (House of Representatives 1995: 1054).

Although Congress passed the Medigrant legislation as part of its Balanced Budget Act of 1995, President Clinton vetoed the bill, thereby precipitating a shutdown of the federal government. In his veto message, the president explained that the conversion of "Medicaid into a block grant with drastically less spending" was, among dozens of others, one of the objectionable provisions that justified his veto of the budget bill. The president maintained that it was essential to protect Medicaid as an open-ended entitlement, adding,

Title VII [of the BBA of 1995] would have cut Federal Medicaid payments to States by $163 billion over 7 years and converted the program into a block grant, eliminating guaranteed coverage to millions of Americans and putting States at risk during economic downturns. States would face untenable choices: cutting benefits, dropping coverage for millions of beneficiaries, or reducing provider payments to a level that would undermine quality service to children, people with disabilities, the elderly, pregnant women, and others who depend on Medicaid. I am also concerned that the bill has inadequate quality and income protections for nursing home residents, the developmentally disabled, and their families; and that it would eliminate a program that guarantees immunizations to many children. (H.Doc. 104-141)

In January 1996, President Clinton issued a second veto related to the Republican's proposed welfare reform legislation (this time a stand-alone piece of legislation, H.R. 4). President Clinton expressed his concern over the consequences that repealing the individual entitlement to cash assistance would have upon Medicaid eligibility. "Welfare reform must be considered in the context of other critical and related issues such as Medicaid and the earned-income tax credit," explained the president (H.Doc. 104-164).

Estimating the counterfactual impact that enactment of the federal capitation and increases in FMAPs would have on Medicaid spending is difficult. The ceiling on the federal appropriations would have had a definite impact on reducing and controlling the rate of growth in the federal government's Medicaid liability, but it is less certain what the changes to federal incentives would mean for the states' own spending commitments.

Assuming that the states would have drawn down their full federal allotments, Jeanne Lambrew (2005: 12) calculated the seven-year *federal* savings at approximately $18.5 billion, just two percent, compared to actual federal spending. (All of the savings were accounted for in the last two years of the 7-year authorizing legislation, however, and so any hypothetical federal savings over the baseline would have

increased significantly over the long-term as the disparity between the federal cap and actual spending increased.) She was silent, however, on the impact that reforms would have on state-, and therefore, net spending on Medicaid.

How the Medigrant Legislation Alters a State's Incentives to Finance Medicaid

To explore the *potential* implications that raising the FMAP might have for state spending, lets consider how the Balanced Budget Act of 1995 might have affected New York's Medicaid spending:

In fiscal year 1995, New York's Medicaid program totaled $23.5 billion: the federal-share was $12.0 billion and the state-share was $11.5 billion. The Medigrant proposal allotted New York $12.9 billion for fiscal year 1996, an increase of 7.5 percent over the previous year's federal-share.

If New York's FMAP remained at 50 percent, the state would have to spend $12.9 billion from its own resources to get its full federal allotment—for total spending of $25.8 billion. The growth in overall Medicaid spending would have been high, but within historical averages.

The Medigrant proposal revised the FMAP formulary, however. The reform would have increased New York's matching rate from 50 percent to 60 percent. As a result, instead of having to meet half of all Medicaid costs, New York could contribute only 40 percent. Without any explicit maintenance-of-effort requirement, New York could spend $8.6 billion and draw down its entire Medigrant allotment. With this level of fiscal commitment by the state, total spending would be $21.5 billion, an overall reduction of 8.5 percent compared to the previous year. Further, the state-share would have declined an unprecedented 25 percent to $8.6 billion, freeing $2.9 billion in state revenues.

However, regardless of whether New York's total Medicaid spending totaled $25.8 billion or $21.5 billion, or something in between, the federal government would have subsidized the same amount: $12.9 billion. If total spending fell below $21.5 billion, the Treasury would compensate New York at 60 cents on the dollar. While at $25.8 billion in total spending, the effective share paid by the federal government was 50 percent, in reality the last $3.9 billion would have been fully paid by New York taxpayers. In economic terms, the marginal cost for every dollar beyond $21.5 billion increased from 40 cents to a full dollar—not 50 cents. To justify spending anything beyond the Medigrant threshold, the taxpayers would have to feel they received a dollar-worth of value for each additional dollar of taxes committed to Medicaid.

Whereas in the past, New York taxpayers would have compared a dollar of additional Medicaid spending to just 50 cents of unsubsidized spending on, say, education, now all these competing budget items could be assessed on an equivalent basis. What seemed like a worthwhile trade-off in the past may no longer appear as attractive. How Albany would have responded to the combination of a maximum federal transfer and a tiered federal match would have depended on the preference order that New York taxpayers used to judge Medicaid expenditures relative to other uses of state revenues (as well as the political strength of providers and recipients to protect their appropriations).

Senator Moynihan's More Equitable Funding Formula

Though ultimately unsuccessful in 1981, President Reagan and his Senate Republicans had nearly succeeded in fundamentally reforming Medicaid by capping the federal government's commitment to the states. At the same time that his colleagues were debating how large of a reduction to Medicaid should be included in the fiscal year 1982 budget (see S.Con.Res. 9), Senator Daniel Patrick Moynihan (D, N.Y.) the freshman Democrat from New York had the audacity to introduce two alternative proposals, S. 853 and S. 855, that would have significantly increased the federal government's fiscal commitment to Medicaid (and welfare generally).

"Let every senator understand two things: First, we are not talking about a program that has covered all those in need; and, second, the changes to come will occur because of fiscal pressure from this administration, not because the need suddenly vanished," explained Senator Moynihan referencing Medicaid and rebutting President Reagan's effort to block grant Medicaid and limit the size of the welfare state (*Ibid*, 6122).

Having introduced similar bills in the 96th Congress (1979-80; see S. 2073 and S. 2574), Senator Moynihan explained how his two bills "illustrate alternative approaches to the solution of a large and pressing problem: the crushing and inequitable fiscal burden created by the current system of apportioning responsibility for AFDC and Medicaid among the three levels of Government in our federal system" (Congressional Record 127(4-5): 6106).

Senator Moynihan, who served in the Senate from 1977 through 2000, was well qualified to offer criticism of the FMAP formula's calculation of the states' relative need for federal assistance. Over his thirty-plus years in Congress, Senator Moynihan maintained the view that the status quo with respect to FMAP formula was inequitable to New York and certain other states because it failed to accurately reflect

the true variation in the states' welfare needs and the states' real ability to pay for the welfare needs of its residents.

Beginning his inaugural year in Congress and continuing until his retirement in 2000, the senator commissioned an annual report, "The Federal Budget and the States", that quantified New York's (along with the other 49 states) balance of payments with the federal government His reports consistently showed that the residents of New York sent significantly more federal income taxes to Washington than the state received in federal appropriations. The senator did not argue for an absolute equalization of per capita federal revenues from the states nor did he demand uniformity in per capita federal outlays to the states; Senator Moynihan accepted that certain states with their comparatively higher per capita incomes would, on average, necessarily pay more federal taxes to the IRS then they received. Raising New York's FMAP would not eliminate the state's net intergovernmental imbalance of payments. However, Senator Moynihan, and several state officials since him, noted, that if Washington sufficiently reformed the FMAP formula so that Albany received what these politicos perceived as New York's equitable share of federal Medicaid dollars the state could greatly reduce, if not eliminate altogether, its annual budget deficits.

More so than the negative balance of payments that may result from a state receiving comparatively fewer federal appropriations for, say, defense contracts or national park maintenance within its borders, any inequities in the level of federal transfers associated with Medicaid (or AFDC, for example) will have direct fiscal implications for state and local governments. Whereas the absence or shortfall in most federal appropriations does not necessarily need to be made up at a lower level of government, Medicaid as a jointly funded federal-state entitlement program that requires complementary commitments by the states and federal government for certain mandated services. Thus, any misallocation of federal Medicaid payments to a state would mean that the state would have contributed a greater (or lesser) amount of its own-source revenues to the program than the state should have if the federal funds were properly allocated.

For Medicaid, those federal allocations to the states are, theoretically, based on the states' respective abilities to pay for their residents' redistributive welfare needs.

Senator Moynihan's argument is that despite New York's aggregate wealth, its relative need for federal assistance is greater than is indicated by the FMAP formula. Based solely as it is on the states' relative per capita personal incomes, the funding formula fails to take into consideration New York's relatively high poverty rate and high cost of providing health care to the poor. The poor, by definition, have few taxable resources and so with a relatively large population living in poverty, the proportion of its residents that New York can effectively tax is smaller than other states with a lower poverty rate. Thus, the taxpayer burden imposed by Medicaid on actual taxpaying New Yorkers will be much higher than for the residents in states with similar, or even lower, per capita incomes but a more normal distribution of personal incomes. It simply is not feasible, argued Senator Moynihan, for New York to raise the revenues needed to meet a full half of the costs of its Medicaid-related expenditures.

Both of the proposals that Senator Moynihan introduced in 1981 went a long way to correct what he perceived as a great inequity for New York in large part by simply increasing the national federal share and therefore narrowing the range of matching rates across all the states. His first bill, S. 853, ostensibly federalized payment of Medicaid and AFDC by increasing every states' Federal medical assistance percentage to 90 percent by 1985. As preliminary a draft as the proposal may have been, the senator claimed the support of former President Jimmy Carter (D) and suggested his reform was in accordance with both the Democratic Party's 1980 platform that had characterized the nation's welfare system as "inequitable and archaic" as well as the (Democratic-controlled) National Governors' Association platform that had long maintained, "the Federal Government…should move toward primary responsibility for welfare and Medicaid" (Ibid. 6101). At least with the latter, Senator Moynihan could add President Reagan as a supporter, if his 1982 proposed swap (introduced in the previous section) was any indication.

Significantly, the proposal seemed to allow the states to retain administrative responsibility for establishing the specifics of their Medicaid program. Although Senator Moynihan claimed that the 10 percent state share was sufficient to ensure state efficiencies, the moral hazard that this cost sharing arrangement created for the Treasury would have worsened the very inflationary tendency of Medicaid that Congress and the president were concurrently seeking to resolve.

The senator's second bill, S. 855, the Medicaid Formula Modernization Act, was less drastic in comparison to the former, but still amounted to a fundamental reform of the FMAP formula and, therefore, Medicaid. It would become a regular proposal from the senator from New York, and although the Government Accountability Office included a variant of it in its OBRA '81-mandated study of the potential impact of various Medicaid reforms on state and federal budgets, Congress would never take it up for debate, either on the floor or in committee (for reasons that will soon become apparent). Nonetheless, Senator Moynihan would relentlessly argue that it was necessary to reform the "perverse and inequitable" federal-state matching rates (Ibid. 6101).

Senator Moynihan's revised formulary amended the current FMAP calculation that he characterized as "entirely arbitrary" in three important ways that he argued would better reflect the states' real ability to pay for Medicaid:

First, it reformed the proxy used in the FMAP calculation to measure the states' tax capacity. It adjusted per capita income to reflect the cost-of-living differences among states and it eliminated a state's need-based public transfers. Including in-cash payments such as SSI or AFDC to welfare recipients as personal income double counted a certain proportion of the states' net income: counting it first as income earned and then taxed by state and local governments and counting it, a second time, as income subsequently redistributed to the state's welfare recipients. Senator Moynihan complained that any state

with liberal—but not egregious, (never!)—welfare policies would be unfairly penalized because its per capita incomes would be the most overstated and its corresponding federal match most negatively affected.

Second, Moynihan's reform eliminated the squaring of the per capita income, thereby reducing the impact that a low per capita income would have in increasing a state's federal share relative to a wealthier state. According to Senator, there has never been any evidence to suggest that a State's need for Federal matching funds is geometrically related to the ratio of is income to national income levels and so the squaring mechanism only aggravates problems resulting from reliance on per capita income (*Ibid*: 6105-06). The senator would later recount a 1977 commencement address he gave, in which he suggested, "only half jokingly," that the squared function should be replaced with the square root. He reasoned, "If you are going to have algebra in Federal statutes, why not turn it our way?" (*Congressional Record* [1997]: S8725)

Third, Moynihan's proposed formula decreased from 0.45 to 0.35 the FMAP multiplier that determines the state share, thereby increasing the federal share that is reimbursed to the states and lessening "what must be acknowledged as an unimaginable burden on the States, and, often on local governments" (*Congressional Record* 127(4-5) [1997]: 6106).

Coupled with the Senator Moynihan proposal made receipt of the more generous federal match dependent upon states adhering to a higher national standard for state AFDC payments and food stamp benefits, of at least 75 percent of the official poverty line (significantly higher than what many states currently pay).

Although the proposals neither attracted a co-sponsor nor were they given a hearing in committee, all of the criticisms and recommendations voiced by Senator Moynihan (at least with respect to the Medicaid Formula Modernization Act) would be thoroughly reviewed by the GAO as mandated by OBRA '81.

Moynihan's Equitable FMAP Redux

Senator Moynihan would make repeated attempts to amend the equalization formula over the next two decades. For example, in 1999 he introduced a bill to amend Medicaid "to provide for an equitable determination of the Federal medical assistance percentage." Moynihan described the FMAP as "a somewhat exotic creature" that could be described as "the South's revenge for the Civil War" (*Congressional Record—Senate* 1999: S634; see S. 203)

While Senator Moynihan accepted that "perhaps in the 1950s and 1960s, per capita income was the best available indicator of a state's wealth"; however, new measurements of state need were readily available from the Census Bureau and Bureau of Labor Statistics that made such rudimentary estimations obsolete. (Ibid)

Worst than the arbitrariness of the FMAP function, "squaring the ratio of state per capita income to national per capita income exaggerates the differences between States with regard to this inadequate proxy for both wealth and of population in need of assistance" (*Ibid.* S634). Earlier Moynihan had "only half jokingly" suggested "why not square root [the per capita income values]?" He reasoned, "if you are going to have algebra in Federal statutes, why not turn it our way?" (*Congressional Record—Senate* 1997: S8725).

Senator Moynihan referred his colleagues to one of many GAO reports that studied the FMAP formula and Medicaid inequity across the nation.[45] GAO work has consistently raised concerns about the

[45] Congress has repeatedly asked GAO to examine ways to improve the allocation of Medicaid funding. A non-exhaustive list of GAO Reports that explore alternatives to the Medicaid funding formula include:
1983. "Changing Medicaid Formula Can Improve Distribution of Funds to States." GAO/GGD-83-27.
1995. "Medicaid: Matching Formula's Performance and Potential Modifications." GAO/T-HEHS-95-226.
1999. "Medicaid Formula: Effects of Proposed Formula on Federal Shares of State Spending." GAO/HEHS-99-29R.
2003. "Medicaid Formula: Differences in Funding Ability among States Often Are Widened." GAO-03-620.
2013. "Medicaid: Alternative Measures Could Be Used to Allocate Funding More Equitably." GAO-13-434.

FMAP, noting that per capita income does not accurately represent states' populations in need of Medicaid services or states' ability to finance services, and does not account for geographic cost differences among states. Consistent with its past findings the 1995 Report damningly concluded, "the current formula has not moderated disparities across the states with respect to the population and benefits Medicaid covers." The report suggested, "the use of per capita income to reflect a state's wealth sometimes overstates or understates the size of a state's poverty population and its financial resources" (quoted at *Congressional Record—Senate* 1999: S634).

A GAO Report on Senator Moynihan's proposed equitable FMAP found that 38 states would see its federal rate drop whereas 7 would see an increase and 8 states would see no change due to legislative constraints on the minimum allowed EFMAP.[46] Not surprising given who was the bill's sponsor, New York

[46] Maintaining the current allowed range for the federal share of 0.50 to 0.83, the EFMAP equation is as follows:

$$\text{"Equitable" FMAP} = 1.00 - 0.45 \frac{\text{state share of RESOURCES}}{\text{state share of NEED}}$$

where,

$$\text{state share of RESOURCES} = \frac{\text{cost-adjusted Total Taxable Resources in state}}{\text{cost-adjusted Total Taxable Resources in all states}}$$

and,

$$\text{state share of NEED} = \frac{3.6 \times \#\text{ of elderly poor} + 1.0 \times \#\text{ of adult poor} + 0.5 \times \#\text{ of children}}{\text{weighted \# of people in need in all states}}$$

A **state's share of resources** is a proxy for the value of the fiscal resources available to a state to fund Medicaid. This proxy depends on the relative value of a state's total taxable resources ("TTR"), a statistic reported annually by the Secretary of the Treasury that begins with state's gross state product ("GSP") and adds any personal income of residents not included in the GSP. This number is then adjusted to reflect the local cost of providing health care services, using the method employed to determine the federal grant allocations to states under the Substance Abuse and Mental Health block grant.

The **state's share of need** is also based on measurements already being collected by the government. A proxy for a state's level of need for Medicaid services is calculated by making two adjustments to the official poverty count reported by the Census. First, the official poverty income threshold is adjusted in each state to reflect variation in cost of living using as a proxy the cost of rental housing in the states. These revised income thresholds are then used to tabulate the number of poor in the state. Second, because of the very different costs in providing care to an elderly population than with adults or children, the EFMAP assigns age group weights to the poverty counts for elderly,

would see the greatest benefit, with its federal share increasing from 50 to 69 percent of its Medicaid spending; had these revised federal matching percentages been applied to FY 1997 spending, New York would have received about $17.1 billion in federal assistance instead of the $12.4 billion it actually received, an increase of 39 percent. California would gain $3.3 billion and another five states would get a total of $750 million. In contrast the 38 states would lose an average of $180 million each in federal funding.

With such lopsided benefits and all governors objecting to the crippling costs of Medicaid it is not surprising that the formula was a non-starter. Although Senator Moynihan's bill offered a serious policy rationale for amending the funding formula it was a profoundly unserious political document.

GAO Agrees, "Changing Medicaid Formula Can Improve Distribution Of Funds To States"

In March 1983 the Government Accountability Office released its report that had been mandated by OBRA '81 (GAO 1983). The report, entitled, "Changing Medicaid Formula Can Improve Distribution Of Funds To States," is notable as the first significant study by the government to specifically critique the FMAP formula. More than two decades and $150 billion in federal appropriation after Secretary Flemming admitted during the 1960 hearings over Kerr-Mills Act that the "question of an equalization formula is certainly a debatable one" the FMAP formula was given a thorough examination.

The GAO's blunt conclusion was, "The formula used to establish Federal reimbursement rates for State Medicaid spending is not as equitable to States as it could be" (GAO 1983: i).

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adults 21-64 and children under 21. Based on a average cost and participation rate among Medicaid recipients the weights are: 3.6 for elderly, 1.0 for adults and 0.5 for children.

In making their policy recommendations for its improvements, the analysts weighed what they perceived as three interrelated objectives of the funding formula as implied by legislative history of Medicaid: (1) narrowing the interstate variation in Medicaid benefits; (2) reducing the disparity in distribution of state tax burden associated with Medicaid, and; (3) controlling the rate of increase in Federal Medicaid funding. The analysis presented several alternatives to the current cost sharing arrangement that reduced "the inequities inherent in the formula."

The GAO cautioned their principals in Congress and Executive, "no single formula change will equally address the three objectives" (Ibid).

The GAO was thorough. It seriously explored the implications of amending the federal-state cost sharing arrangement and took into consideration a wide variety of potential factors, including state-level poverty rates and unemployment rates, the number of Medicaid recipients, and cost-of-living differentials. The GAO examined the potential impact of reducing the federal minimum and lowering the overall federal share (currently 55 percent for a state with a per capita income equivalent to the national median) and including general incentives for either increasing or decreasing state-level spending. Some potential reforms they dismissed for practical reasons and others for conceptual reasons after weighing the availability of reliable data and the implications of the variable to the formula.

All the funding formula options they considered resembled the following equation:

$$\text{State Share} = K \times \left[\frac{\text{State tax capacity per person in poverty}}{\text{U.S. tax capacity per person in poverty}}\right] \times \left[\frac{\text{State Mediciad spending per person in poverty}}{\text{U.S. Medicaid spending per person in poverty}}\right]^{1-\propto}$$

Where the federal share is 100 percent minus the State share with a specified minimum and maximum. K is the formula's constant—a smaller constant produces overall lower state shares. (Currently

K = 0.45; Senator's Moynihan recommendation was to lower K to 0.35, whereas the GAO considered raising K.) The exponent, $1 - \alpha$, is an incentive factor that would adjust the federal share based on the states' relative spending on Medicaid—a state that spent more than the norm would have to pay a greater share; conversely, a state spending less would have a more generous federal share (reducing $1 - \alpha$ to zero would eliminate the incentive term from the formula altogether) (Ibid: 97-98).

Although the GAO explained the strengths and weaknesses of the incentive term, the nonpartisan researchers concluded that its inclusion was ultimately a political calculus to be decided by elected officials.

In contrast, the GAO was insistent that Congress moves away from per capita income as a proxy for the states' relative tax capacity and tax burden. "The use of per capita income to reflect a state's wealth sometimes overstates or understates the size of a state's poverty population and its financial resources," explained the GAO.

Noting that state income taxes accounted for only about a fifth of state revenues the GAO recommended the greatest improvements to the funding formula could be achieved by substituting personal income with a broader measure of a state's true tax capacity that included other potential sources of tax revenue, such as natural resources, property and corporate sales—the GAO recommended the Representative Tax System (RTS) pioneered by the Advisory Commission on Intergovernmental Affairs. The GAO also argued that controlling for the number of residents below the poverty line would be a marked improvement in the funding formula (and preferable to an estimate of actual Medicaid recipients). These substitutions contributed to a better accounting of a state's fiscal capacity and the potential tax burden of its needy.

Even if the RTS was substituted for personal income in determining the relative fiscal capacities of the states, significant inequities would remain: for example, the GAO identified that the 50 percent federal

share minimum prevented the FMAP formula from offsetting the comparative disadvantage of poorer states. However, the GAO conceded that even if they could design a funding arrangement that perfectly equalized the states' tax burdens and fiscal capacities, the formula would not fully resolve program disparities because "many social, economic and political circumstances influence a State's selection of Medicaid benefits to be provided" (Ibid, 10). For whatever reason, the median New Yorker is simply willing to pay more toward the health care costs of their poor neighbors than the typical Texan.

The GAO's recommendations offered significant credibility to Senator Moynihan and even Representative Brown's arguably self-serving (to their home states, at least) critiques of the existing Medicaid formula.

Despite New York having the nation's costliest Medicaid program, accounting for 18 percent of federal outlays for the program in 1981, its modest tax capacity and large poverty population meant the state's tax burden was (and remains) relatively high compared to most other states. Although the GAO did not specifically score the New York senators' proposed formula and rejected some of his specific grievances with respect to the current FMAPs, each of the GAO's potential reforms "significantly raise the Federal share for New York because of its relatively large poverty population and low tax capacity." For example, by factoring in the number of residents in poverty and replacing squared per capita income with what it perceived to be a better measure of the states' true tax capacity, the GAO calculated that New York's federal share for fiscal 1981 would have increased over 25 percent, from 50.88 to 64.21 percent.

The government researchers were not so naïve as to not recognize that their recommendations "could be considered unfair to the other States if they must suffer reductions in their programs to make up for New York's increase, because such reductions would have to be made in many cases in programs already less generous than New York's" (Ibid: iv). Specifically, in contrast to New York's fate, the funding formula

proposed by the GAO that they assessed as most significantly reducing interstate variation would have resulted in 39 states with smaller Federal rates and in 30 of theses states the reduction would be greater than 5 percent (Ibid: 36). Reducing the minimum federal share to an arguably more equiTable 30 percent share (as was recommended by Senate Republicans in 1981) would have impacted thirteen states alone.

Despite the GAO's comprehensive study and its specific policy recommendations for reforming the funding formula, the recommendations had no political potential. In fulfilling the objectives set by OBRA '81 the GAO's recommendation created a net number of losers. Given the need for any policy change to be passed by at least a majority in the House and a supermajority in the Senate, reform was unlikely. Officials in the administration who commented on the GAO's recommendation captured the futile reality thusly, "The introduction of the RTS, although theoretically appealing, represented a major change in the present formula and that it might be desirable to present options which represent lesser changes to the formula" (*Ibid*: 58).

Medicaid Expansion During the Ronald Reagan and George H.W. Bush Era

While President Reagan continued to target Medicaid with deep cuts in each of his budgets, a diminution in Medicaid inflation and stability in enrollment lessened the impetus for any attempts to fundamentally reform the program for the remainder of Reagan's first administration—compared to the average annual expenditure growth of 15 percent between 1976 and 1981, the rate of growth dropped to an average of less than 8 percent between 1981 and 1984.

Following the failed reform initiatives in 1981 and 1982 the Reagan administration ostensibly ceded leadership over Medicaid policy to Congress—a Congress that, as Larry Brown observed, was

"unexpectedly adept at generating health policy leadership" (Brown 1990: 294). For example, the Democrat-controlled Congress refused to extend the temporary reduction to the federal share included in OBRA 1981 after the cuts expired in fiscal 1984 and had no problem protecting Medicaid from any further cutbacks or changes to its basic funding structure (Rowland, Lyons and Edwards 1988: 236). As Representative Henry Waxman explained, "the irony of [OBRA '81] was that it developed an enormous amount of support for the Medicaid program which helped us throughout the '80s in expanding Medicaid" (Smith and Moore 2003-06: 745).

Rather then fending off additional cuts, Congress would successfully pass a series of incremental reforms throughout the Reagan and Bush administrations that cumulatively resulted in a massive increase in the number Americans eligible for Medicaid. Motivating the Democrats' liberal reform agenda was the observation that stagnation in Medicaid enrollments over the past decade had contributed to a significant widening of the gap between the number of Americans in poverty and the number of Americans enrolled in Medicaid. With Medicaid eligibility still restricted to those with household incomes less than 133 percent of a state's AFDC limit and states failing to consistently raise their cash assistance welfare limits to keep up with inflation, the result was retrenchment and even a decreasing rate of Medicaid participation among the poor in many states. Further exasperating this trend, certain federal regulations included in OBRA '81 restricted the amount of income and resources that AFDC recipients could exclude in determining Medicaid eligibility. Measured as a percentage of the federal poverty level, the states' Medicaid eligibility criteria dropped from an average of 55 percent in 1980 to 47 percent in 1984; in five states the penetration was less than 25 percent (Rowland et al. 1988: 432-33, Table 1).

The inability of many poor Americans to pay the high costs required of the nation's health care system led state officials and public health advocates to beseech Congress to expand Medicaid's eligibility criteria. In 1983, Representative Waxman culled from former President Jimmy Carter's health reform

platform a proposal for a Child Health Assurance Plan that would have provided full federal funding for expanded Medicaid coverage for first-time pregnant women and for poor women and children in families in which main wage-earner is unemployed. Republicans in the Senate, however, countered with a more modest proposal that would have required states to cover only first-time pregnant women who had qualified for AFDC at existing matching rates. To protect his own plan, Representative Waxman attempted to attach his proposal to the Ways and Means reconciliation bill that would be taken up together as part of a large tax bill and subject to more restrictive congressional rules. The legislative maneuver was rebuked.

Through experience, however, Representative Waxman would learn how to expertly use the reconciliation process—the same legislative vehicle used by Republicans to enact the reduction in Medicaid expenditures in 1981. As chair of the Energy and Commerce Subcommittee responsible for Medicaid policy, Representative Waxman would repeatedly coopt the reconciliation process to pass incremental, yet cumulatively significant, expansions to Medicaid. Taking a lesson from his failed reform attempt in 1983, Representative Waxman learned to concede certain "pragmatic accommodations" out of political necessity in order to extend Medicaid services and eligibility (Brown 1990: 294). As Federal Assistant Secretary for Planning and Evaluation (within the Department of HHS) Robert Helms, described, Representative Waxman was "a very clever guy who was always able to get in a little expansion of a program here and there over the years" (Smith and Moore 2003-06: 236).

By arguing that it was both efficient and morally right to more adequately provide for the health care needs of pregnant women and their children, Representative Waxman garnered endorsements from the Children's Defense Fund, the American Academy of Pediatrics and the US Catholic Conference. Representative Waxman successfully courted social conservatives in Congress, such as Representatives Henry Hyde (R, Ill.) and Thomas Biley (R, Va.), who saw health care as essential to minimizing pregnancy terminations and to ensure the health of newborns (Ibid: 298). Motivated by what many perceived as an

unacceptably high mortality rate of infants and the poor health of children in the United States, Democrats and Republicans, alike, accepted the direction of Medicaid's focused expansions.[47]

Despite dropping the provision that an expansion should be fully federally funded from the Treasury, Representative Waxman managed to retain, at least initially, the support of the states and their governors. Sarah Shuptrine, who during the Eighties served as senior staff to the Southern and National Governors' Associations, identified "a number of very progressive Governors" and public health advocate in the South whose "leadership" was essential for ultimate passage of the Medicaid-related amendments in the mid-Eighties. Although she credited Representative Waxman as "very supportive" and someone who "provided strong leadership on the House side" and identified the bipartisan support of Ted Kennedy (D, Mass.) and Strom Thurmond (R, S.C.) as being critical to passage in the Senate, her account depicted a policymaking process motivated by state-level public officials, particularly those from southern states, who were empathetic to the plight of their poorest residents (Smith and Moore 2003-06: 590).

With the willingness of some Republicans to tacitly oppose their president's budget priorities, the Deficit Reduction Act of 1984 (DEFRA) (P.L. 98-369) included a compromise mandate requiring states to

[47] Researchers estimate that Medicaid paid for 10 percent of all births between 1979 and 1982 (Kenney et al. 1986), 15 percent of births in 1985 and then more than doubling as a result of the reforms of the later part of the Eighties to 32 percent of births in 1991 (Singh, Gold, and Frost, 1994). In 2010, Medicaid covered approximately 41 percent of all births, with Medicaid in poorer states such as Mississippi and Louisiana paying for approximately three-fifths of all births (statehealthfacts.org; for review of research on Medicaid family planning services see, Howell 2001).

Such a trend was the direct consequence of in proposing the George H.W. Bush administration's "new focus on the nation's problem of infant mortality and morbidity", Louis Hays, then-Director for Health Care Financing Administration (HFCA), explained:

As a major source for financing the health care of low-income pregnant women, who are most at risk, Medicaid already offers services that make a difference in pregnancy outcomes. But more help is needed….With this in mind, the bill submitted to Congress by the Administration…calls for Medicaid coverage of pregnant women and infants up to 130 percent of the federal poverty level. (Hays 1990, 496)

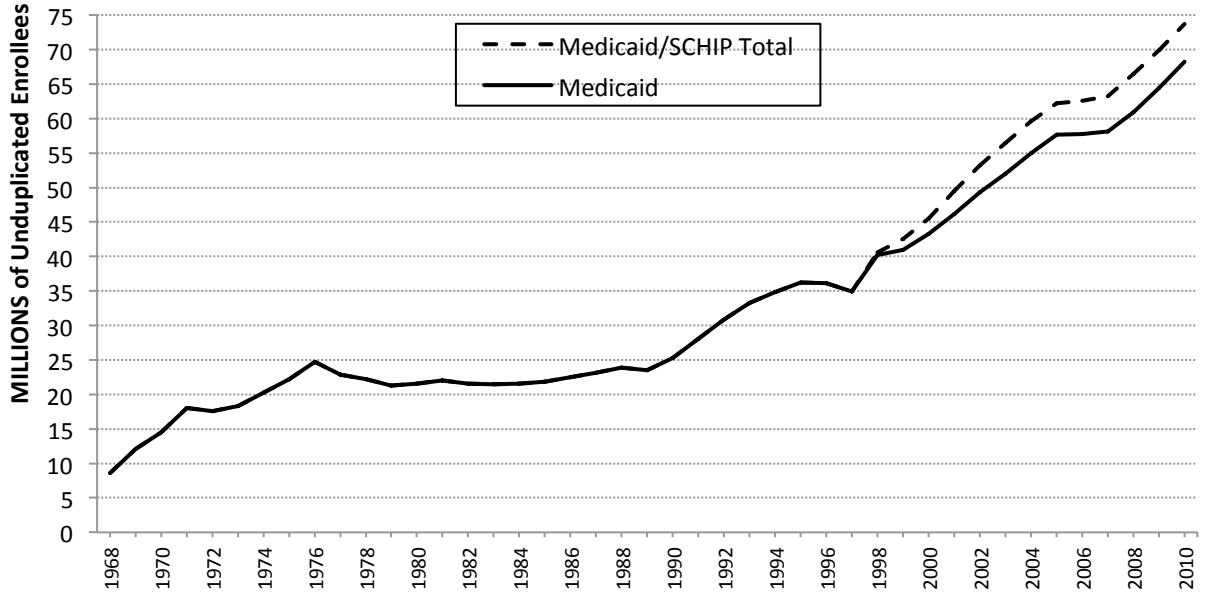
expand Medicaid coverage to poor women pregnant for the first time who would be eligible for Medicaid once the child is born as well as pregnant women in two-parent families in which the principal wage earner is unemployed, and to poor children up to the age of five in two-parent families that met their state's AFDC eligibility standards.

Thereafter followed a series of reforms progressively expanding Medicaid eligibility that were included as amendments to half-a-dozen reconciliation laws: the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) (P.L. 99-272), OBRA 86 (P.L. 99-509), OBRA 87 (P.L. 100-203), OBRA 89 (P.L. 101-239), and OBRA 90 (P.L. 101-508).

Each subsequent expansion built upon the previous one to greatly diminish the relationship between Medicaid and AFDC. Sandra Tanenbaum described how before the eligibility expansions of the mid- to late- 1980s, reflected a "utilitarian" incrementalism that so weakened the relationship between Medicaid and a notion of welfare deservingness that tied to "blameless economic insufficiency" that one can "justifiably speak of pre- and post-OBRA eras of the program" (Tanenbaum 1995: 936, 937).

Cumulatively over a ten-year period, Congress had quietly mandated the states to cover pregnant women and children under 6 with incomes at or below 133% of the FPL, cover children ages 6 through 18 in families with incomes at or below 100 percent of the poverty line (by 2002), pay the premiums and cost sharing liabilities of Medicare beneficiaries at or below 100 percent of poverty (by 1992) and the premiums of Medicare beneficiaries between 100 and 120 percent of poverty (by 1995). The result was and significant increase in the number of insured through Medicaid after an extended period of stagnation and retrenchment. **Figure 4.3** charts the annual enrollment counts between 1980 and 2012.

Figure 4.3. Annual Cumulative Count of Unduplicated Enrollees in Medicaid (or CHIP), FY1968-2010



Notes: Enrollment Data reflect cumulative count of unduplicated individuals enrolled in Medicaid (or CHIP) at any point during the year. For example, in 2007 there were 7.1 million children enrolled in SCHIP for part or all of the year; comparatively, there were 4,4 million enrolled in June 2007. The solid Medicaid enrollment figure includes M-SCHIP enrollees in states that do not have a separate SCHIP program.

Sources: Statistical Abstract of the United States (census.gov), Center for Medicare and Medicaid (cms.gov)

Contemporaneous accounts of the Eighties' reforms did not miss the significance of the incremental expansions to Medicaid. Taking stock of the recent legislative achievements of Medicaid, the *New York Times* led with the headline, "Expanded Right to Medicaid Shatters the Link to Welfare" in March 1988 and chronicled the "small" "piecemeal," but "revolutionary steps" that Congress had taken over the past three years to distinguish Medicaid eligibility from welfare eligibility (Pear 1988: A1). The editorial staff at the *Washington Post* similarly described the Medicaid expansions as "a series of soft steps that taken together would have created enormous controversy, has begun to loosen the connection" between welfare and health care entitlements (1987: A22).

Yet, even if the incremental reforms during the Eighties sustained a quantitative change in Medicaid in terms of both fiscal outlays and enrollment, they did not contribute to any real substantive change in the

general demographics of those enrolled. Medicaid eligibility remained strictly tied to the notions of maternalistic deservingness, with most of the expansions were directed toward pregnant women, infants and, later, poor children who were traditionally characterized as excluded from the wage economy and deserving of the charity of a sympathetic state.

Whereas the National Governors' Association had endorsed and even petitioned Congress in support of Waxman's mandate to raise the federal floor on Medicaid eligibility in 1985, by the end of the decade the same state officials were actively petitioning Congress to halt the imposition of more federal mandates. By end of President George H.W. Bush's term in office nearly 36 million Americans were enrolled in Medicaid and total spending for fiscal year 1992 was $120 billion. Compared to the stagnate enrollments and an annual growth rate in costs that averaged 8 percent during President Reagan's first term, enrollment and costs averaged an annual growth rate of nearly 5 percent and 13 percent during Reagan's second term and President Bush's presidency. With the states still phasing in the mandated expansions and medical inflation contributing to an unprecedented increase in per-beneficiary costs, states officials expressed legitimate concern that Medicaid was crowding out competing public expenditures. For many states, Medicaid had become the second costliest line item in their budget, just behind education and/or local transfers.

Chapter 5.

Sustaining Medicaid by Responding to Medicaid's Taxpayer Burden

In 1993, Boston Globe columnist hypothesized, "Decades from now, historians will place the big transition at fiscal 1993, when, for the first time, states spent more on Medicaid than on higher education." Aptly describing Medicaid as the PAC-Man of state budgets, Evan Bayh (D., Idaho) gave the columnist his blunt assessment of fiscal situation facing states, "Health care is destroying state government" (Shribman 1993).

Of course, state governance has not ceased even though Medicaid remains and its expenditures have not abated. In fact, today many states spend more on Medicaid than they do on K-12 education, not just higher education. This chapter explores how the federal government and states adapted to the rising costs of Medicaid by revising the traditional cost sharing arrangement to meet the increasing fiscal burden imposed on the states.

The states would respond first by learning to creatively leverage Disproportionate Share Hospital payments and, later, Upper Payment Limit appropriations to augment their budgets. By offsetting their DSH or UPL outlays with provider-specific taxes on hospitals the states managed to recoup their own-source expenditures and thereby effectively raise the federal share going toward their Medicaid operations. While Congress would quickly respond by redressing what they perceived as an abuse of these so-called Medicaid maximization schemes, by limiting and not eliminating these practices Congress effectively acknowledged the incapacity of the states to meet the cost of their Medicaid commitments.

Further, following the states' own initiatives, the federal government's subsequent reforms to Medicaid would acknowledge the need to rebalance the shared responsibilities for financing Medicaid. The legislative results consistently increased the federal's government proportional responsibility, as demonstrated by: the bipartisan enactment of the State Children's Health Insurance Program ("CHIP") in 1997 (and its reauthorization in 2009), a supplemental block grant that incorporated a more generous federal matching rates; the temporary increases to the state's federal shares in response to economic downturns in 2003 and 2005, and; the enactment of the Patient Protection and Affordable Care Act of 2010 and the Medicaid expansion included therein. These policies all represent an understanding by federal and state policymakers that Medicaid's cost sharing arrangement had become inadequate to meet the broadening societal need for, and public cost of, welfare medicine.

"Medicaid Maximization": The States Leverage DSH and UPL to Meet the Costs of Medicaid

Disproportionate Share Hospital (DSH) Payments

Included as part of the Boren Amendment to OBRA '80 and OBRA '81, Disproportionate Share Hospital (DSH) payments are intended to be supplemental Medicaid reimbursements provided to certain hospitals "which serve a disproportionate number of low income patients" (see Section 1902(a)(13) and Section 1923 of Social Security Act). These special payments are made at the discretion of the state and are eligible for the same federal financial participation as determined by the state's FMAP.

The rationale by these payments is that they are necessary to supplement and make financially whole those hospitals that render high volumes of care to low-income Americans and therefore often lose money as a result of either the low Medicaid reimbursement rates (that the hospitals argue fail to meet even

the actual cost of care) or the high levels of uncompensated care provided to Medicaid-ineligible indigents. DSH payments help relieve the financial burden put upon providers who are ostensibly underwriting the state's charitable care. Ironically, given how DSH payments would contribute to Medicaid inflation, another argument for DSH payments was that these supplemental payments could slow the rate of growth in Medicaid spending because they could be targeted and therefore reduce the need for across-the-board reimbursement rate revisions.

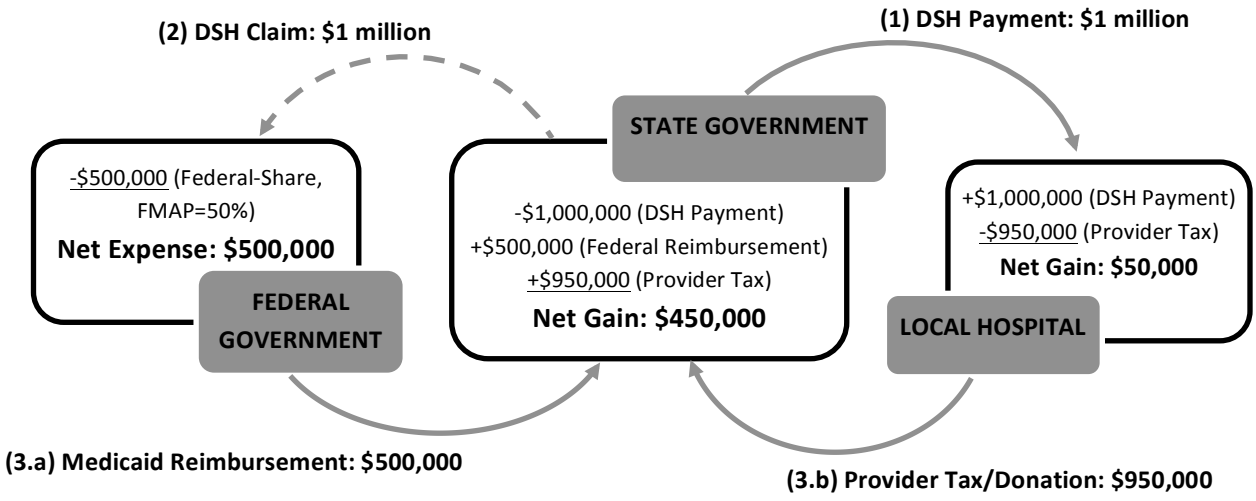
With their already fiscally burdensome commitment to Medicaid, however, most states did not elect to immediately appropriate any additional revenues to healthcare providers. The DSH payments might relieve the financial burden of charitable care imposed on providers, but they would do nothing, on their own, to relieve the increasing state-level taxpayer burden of Medicaid. Any DSH payment would only increase the state's net health spending; as such, there was little incentive for the states to make such optional payments to providers.

DSH payments remained marginal throughout the 1980s, up until state governments discovered provider taxes and donation programs. After states understood how the dynamics of this shell game of monetary transactions could allow them to leverage additional federal revenues without any associated state contribution, the states awarded DSH payments liberally. Many states quickly came to realize they could use supplemental DSH payments to augment their own budgets, not the operating budgets of certain hospitals. The concurrent use of DSH payments with provider taxes or donations has the affect of lowering the relative cost of the state share.

Figure 5.1 depicts the mechanics for how a state government in partnership with a hospital can use a combination of provider taxes to leverage federal dollars: (1) The state appropriates a $1 million DSH payment to a hospital; (2) the state submits a claim for the DSH payment to the federal government; (3.a)

the government reimburses the state for a proportion of the DSH according to the state's FMAP, say 50 percent, so $500,000. (3.b) The state then uses its taxing authority to impose an arbitrary tax on the hospital for, at least, $500,000 to cover its own share of the DSH-payment—the hospital and state could share the residual $500,000 in any manner they see fit. For the example let's assume the hospital retains 5 percent of the DSH payment. Whatever additional proportion the state collects from the provider will be general revenue gained ostensibly at no cost to the state taxpayers and can be used for however the government.

Figure 5.1. Example of How a Disproportionate Share Hospital Payment Can Work to Raise State Revenues



Whether a coercive tax or voluntary donation the two mechanisms served the same purpose: the state could collect money from a hospital and then use that revenue to finance a DSH payment to the very same hospital. Meanwhile each of those dollars repaid to the providers would generate one to four dollars in federal transfers, depending upon the state's FMAP, that the state leveraged at zero cost.

In 1984, Florida became the first state to establish a provider tax program. West Virginia was the first state to use a donation program, in 1985, after the Health Care Financing Administration (now the Center for Medicare and Medicaid) issued a rule clarifying how states could receive donations from private medical care providers. Still, the states were slow to appreciate the fiscal utility of these payments as a source of federal revenues. By 1985, only about a third of the states had specific DSH payment regulations in place and the net amount of supplement federal revenues being drawn down was marginal.

Subsequent provisions in each of the reconciliation bills of 1986 through 1990 greatly encouraged the general practice of states drawing upon federal DSH payments.[48] With state spending on Medicaid steadily rising as a consequence of the recent federal mandates and medical inflation, the states learned—by necessity, they would argue—to use donations and providers taxes as a way to finance the state's portion of the of Medicaid. Whether or not it was the intention of the original law, Congress and the executive gave its tacit support to the practice.

Legislation in the later part of the Eighties supports the characterization that the federal government was complicit in their growth. "Numerous members of both parties in Congress, both liberal and conservative, sought to find ways to assist their home states," observed Jean Donovan Gilman. Offering Senator Warren Rudman (R, N.H.), who co-authored both the fiscally-conservative Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177) and the Budget and Emergency Deficit Control Reaffirmation Act of 1987 (P.L. 100-119), as an example of a senator who despite his opposition to

[48] OBRA '86 (P.L. 99-509) rescinded a HCFA regulation limiting a state's aggregate Medicaid payments for inpatient hospital services to no more than the amount that would have been paid under Medicare payment principles and gave states express permission to make Medicaid DSH payments without limit; the next year, OBRA '87 (P.L. 100-203) required states to submit state plan authorizing Medicaid DSH payments, established DSH eligibility criteria and required minimum payments to reflect Medicaid utilization rate; OBRA '90 (P.L. 101-508) allowed DSH payment to reflect a hospital's low-income (not just Medicaid) utilization rate, separated DSH payments according to type of hospital;, and prohibited executive from changing treatment of provider taxes/donations.

excessive federal spending assisted his state in exploiting the Medicaid program for federal transfers, Gilman added, "Even conservative members of Congress have a difficult time putting their money where their mouths are when the possibility exist to distribute concentrated benefits (especially to powerful interests) in their home states." (Gilman 1998: 194)

In June 1989, the HCFA regulation that states could not require or solicit contributions from providers for the purpose of obtaining federal matching funds (a response to the West Virginia program) was overturned in the courts. This provided a mechanism for states to generate additional federal matching funds without any net increases in their own budgets. The combination of the provider tax or donation programs and a relaxation in allowable DSH payments created the potential of enormous financial advantages for states. Then OBRA '90 extended a moratorium (initially enacted under the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647)) on any federal regulatory changes to the treatment of voluntary contributions and provider-specific taxes.

Between fiscal years 1990 and 1992, as the number of states with a tax or donation program increased from 6 to 39, the total DSH payments soared from under $1 billion to $17.4 billion, accounting for 14.7 percent of total of Medicaid spending in 1992. DSH payments have been identified a major causal factor for the rapid growth in Medicaid spending in the early Nineties, contributing to nearly half of the growth in medical expenditures between 1991 and 1992 (Holahan et al., 1993; Hearne, 2005).

Ultimately the uninhibited growth in DSH payments and rising concerns over the federal deficit led to reforms. With DSH payments exceeding 15 percent of the total Medicaid budget in about a third of the states in 1991, neither Congress nor the executive could ignore the alleged abuses of DSH financing. Too many states were not actually contributing to the state-share of their DSH payments and a large proportion

of DSH spending was not actually going to safety-net hospitals to cover their uncompensated care as Congress intended, but relieving state budget deficits.

The first attempt to reign in the growth (and perceived abuses) of provider/tax programs was the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234). (Incidentally, this legislation represented the first stand-alone piece of Medicaid legislation passed by Congress in its first three decades.) This law capped DSH payments, setting a maximum DSH allotment for each state based upon its historical DSH spending for 1992, with the DSH program (including state share) not to exceed 12 percent of a state's total Medicaid expenditures (Herz 2009).

The 1991 law also addressed certain practices that were used by the states to circumvent their shared responsibility for funding the Medicaid program. The law banned provider donations and required that provider taxes be "broad-based" and uniformly applied within specified classes of providers, thereby preventing the taxation of *only* Medicaid providers. (Other providers could not be repaid by simply raising Medicaid rates, and therefore some providers would likely oppose the imposition of such taxes.) The law prohibited states from making any direct or indirect guarantee to providers that they would be held-harmless for any taxes or donations by reimbursing them with either DSH payments or inflated Medicaid payment rates.

While the 1991 law halted growth in DSH spending, the DSH program continued to be a contentious issue between the states and the federal government. As Mark Reynolds, who served in Massachusetts and Tennessee's Medicaid offices, reflected, "[Y]ou will notice that when Congress had the chance to roll those things back it never did. It might have capped them but it never repealed benefits." As he explained, "DSH became a very big funding tool for safety net institutions at federal expense.... Once

[the Congress and executive] see what the cost of rolling them back is in terms of the impact, that's a very difficult situation" (Smith and Moore 2003-06: 510).[49]

To better assure that the states used the DSH payments as intended, Congress enacted additional legislation in 1993 and 1997 that lessened state flexibility and curbed the worst abuses of DSH financing schemes by the states (Coughlin and Liska 1997).[50]

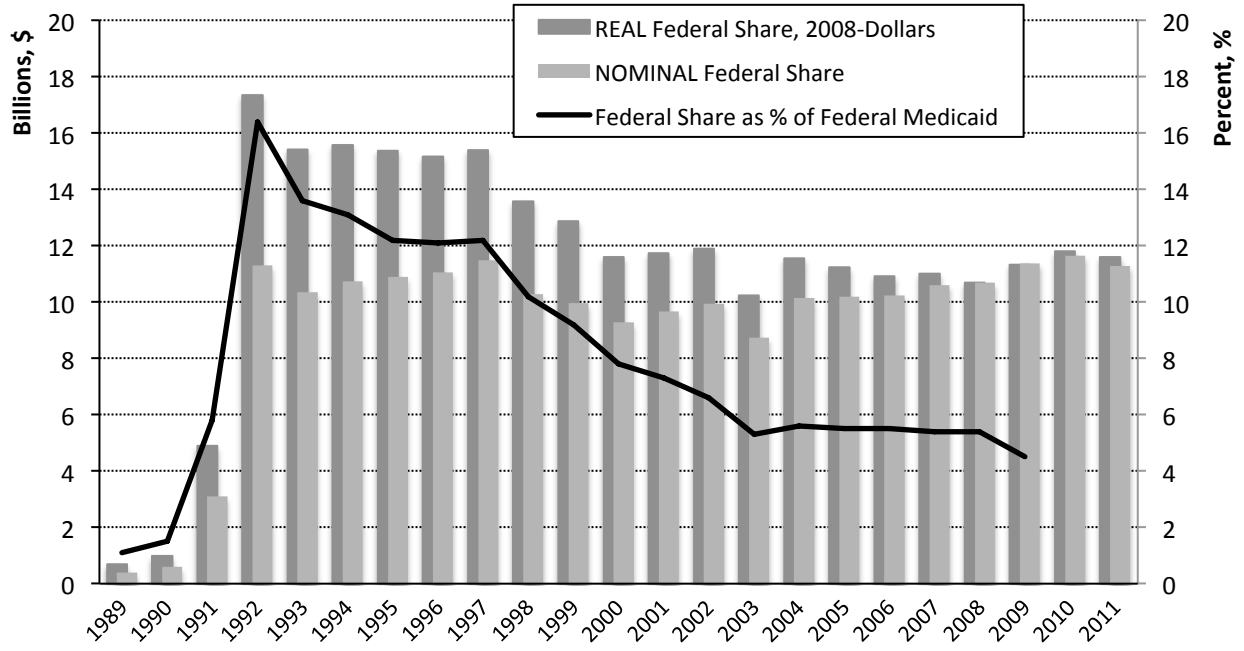
Figure 5.2 presents aggregate federal share of DSH payments for fiscal years 1993 through 2010. The figure represents the federal allotment and not necessarily the actual DSH payments made. The federal allotment represents the maximum amount of DSH a state can distribute and have subsidized according to the state's matching rate. The amount can vary from actual payments because states may either choose to not spend the full amount of concurrent state resources required or the state may exceed the federal amount in a particular fiscal year depending when the payments were made within the state's fiscal year.

[49] Of course, there are legitimate reasons why a state would expect "donations" or impose taxes on hospitals in the state. For example, if there are certain community hospitals that serve a disproportionate number of the state's Medicaid patients and provide a lot of charitable care, it might be reasonable to expect that the state's more affluent hospitals, whose patients are more likely to be fully insured, should bear some of the cost of financing the delivery of care to the poor. (Whereas taxing the recipient of DSH payments defeats the intention of the subsidy.)

[50] The Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) made an effort to better assure that DSH programs were being used for their intended purpose by allowing states to provide DSH supplemental payments to only those hospitals that had Medicaid utilization rate of at least 1 percent of patients. It also imposed the restriction that total DSH payments provided to a single hospital could not exceed the unreimbursed cost of providing inpatient care to Medicaid or uninsured patients. The Balanced Budget Act of 1997 (P.L. 105-33) phased down DSH allotments by 1 percentage point for each year between 1998 and 2002 and, for 2003 and beyond, instituted a CPI-adjusted growth on the states' maximum DSH allotments. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (P.L. 108-173) designated the 16 states with DSH expenditures between 0 and 3 percent of total (state and federal) Medicaid spending in FY 2000 as "low DSH" states and increased their DSH allotment by 16 percent each year from FY 2004 through FY 2008, and by the CPI thereafter. The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) provided for additional DSH payments by increasing all state Medicaid DSH Payment Program allotments by 2.5 percent in 2009 and an additional 2.5 percent in 2010. After 2010, the states' annual DSH allotments returned to the baseline as determined under current law.

Comparing actual DSH payments reported to the HCFA/CMS, federal allotments were drawn at an average rate of about 85-90 percent of maximum allotment throughout the period.

Figure 5.2. Federal Share of DSH Allotment, Nominal and Real Dollars, and Federal DSH Allotments as Percent of Total Federal Share of Medicaid Payments, FY1989-2011



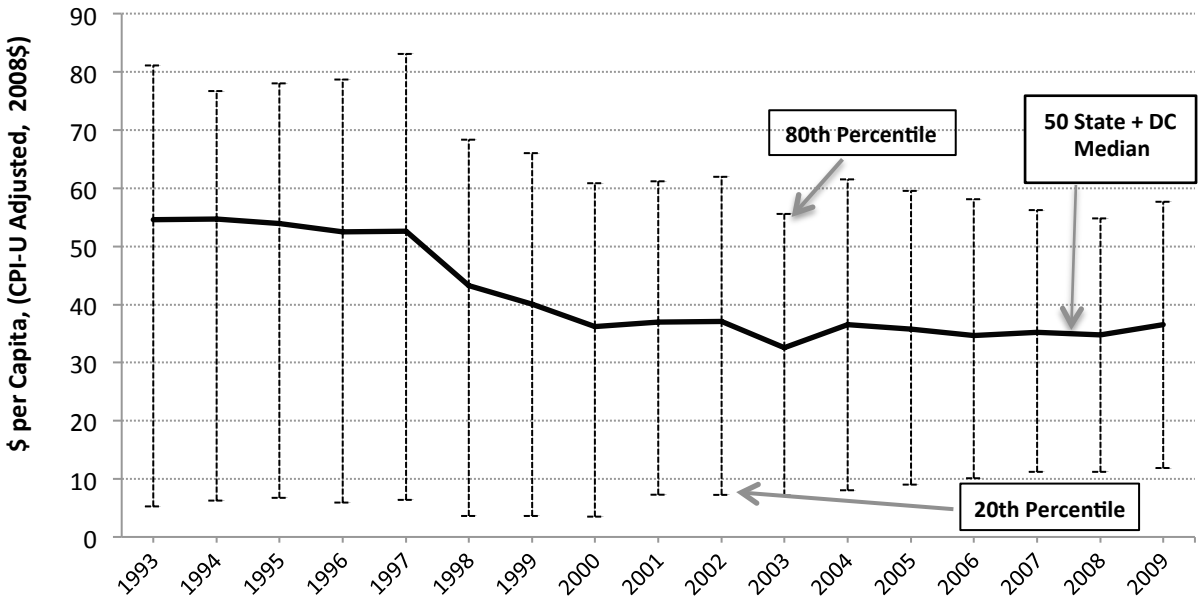
Source. *Federal Register*

There are several ways to measure the equity of the DSH payments to the states. **Figure 5.3** and **Figure 5.4** respectively chart the federal share of DSH allocations per capita and total DSH payments per poor person for such payments across the states between 1993 and 2009, including the state average and 20th/80th percentiles (Hawaii, Tennessee and Arizona are excluded for those years when they had no DSH allocations due to waivers). By considering *federal DSH payments on a per capita level*, adjusted for regular inflation, the cynical analyst can look to **Figure 5.3** to better understand state-level variation in DSH payments from the perspective of general interstate revenue sharing—i.e. this is how much a state can draw down from the Treasury without any real state expenditure if it were able to use provider taxes and intergovernmental transfers to offset the state share. If the DSH payments are ostensibly a form of revenue

sharing (a 1993 survey by Ku and Coughlin (1995) found that about one-third of federal payments were being retained by the states for non-DSH related expenditures), the best way to minimize inequities would be to make sure that each state receives the same federal share per capita.

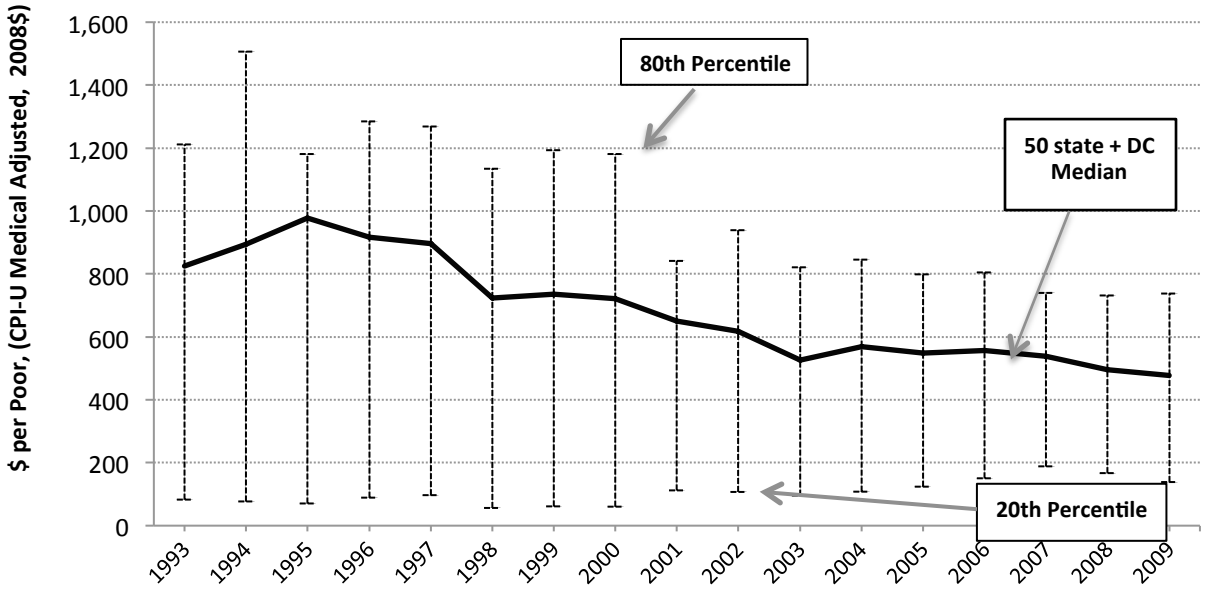
In contrast, if the DSH reforms passed by Congress in 1991, 1993 and 1997 are accepted as having successfully curtailed the worst abuses of DSH funding mechanisms so that the payments are used, as intended, to subsidize hospitals for their uncompensated care, it might be preferable to compare changes to the states' *total DSH payments per person in poverty*. To this end, **Figure 5.4** charts the variation in DSH payments per person in poverty,[51] adjusted for impact of medical inflation to reflect the real value of payments over time. In 2008, the average federal DSH payment per poor person was $475; however, the range went from $10 per poor resident in Wyoming to $3,000 per poor resident in New Hampshire.

Figure 5.3. Federal DSH Allotment per Capita, Real 2008 Dollars, by State, FY1993-2009



[51] I also looked at the DSH payments per the number of uninsured and Medicaid beneficiaries in a state, the two targeted groups of DSH payments (given that DSH payments are intended to subsidized Medicaid shortfalls associated with low reimbursement rates *and* uncompensated care for the uninsured); however, the aggregation of uninsured and Medicaid beneficiaries is unadvised because of double counting.

Figure 5.4. Total DSH Allotment per Poor Resident (i.e. under 100% of poverty), Real 2008 Dollars, by State, FY1993-2009



Regardless of the measure, it is clear that the variation in DSH payments is quite severe. The federal ceilings imposed on DSH payments may have been needed to maintain Medicaid's financial partnership between the states and federal government, the individual ceilings had the affect of locking into place the historical variation in state-level DSH spending patterns. Unfortunately, this variation is often times unrelated to actual need. For example, the correlation between the federal share of DSH payments per capita and the state's FMAP is approximately zero and the correlation between total DSH payments per poor and the state's FMAP is negative (falling from a -0.35 in 1993 to -0.22 in 2009).

The designation of Low-DSH and High-DSH states (with that later being granted greater allowance in their DSH ceiling growth) has narrowed the gap in payments between some states, but significant variation persists.

Included the Balanced Budget Act of 1997 was a significant reduction to Disproportionate Share Hospital payments (estimated at $10.4 billion in federal savings over 5 years). However, DSH-related earmark granted New York a reprieve for certain provider taxes the state had previously collected and the federal government argued violated the provider tax criteria established by OBRA '91 (Coughlin and Liska 1998).

Objecting to the recusal of New York's federal liability that the CBO estimated to be $1.5 billion in disputed DSH payments, President Bill Clinton exercised, for the first time, his recently acquired line item veto authority to rescind the reprieve. President Clinton argued the special treatment awarded to New York went against recently implemented legislative and regulatory guidelines that were intended to curb DSH expenditures. "This preferential treatment [recusing New York of its DSH liability] would have … treated New York differently from all other States," explained President Clinton in his veto message (cited in *Clinton v. City of New York* 524 US 417).[52]

Senator Moynihan subsequently went to the floor to defend New York's accounting and to offer a bill (S. 1144) denouncing his president's unilateral action. The senator argued that the high level of DSH payments would have been unnecessary if New York received an equitable allotment of federal Medicaid dollars, implying that the supplemental federal revenues generated by the DSH payment program served to

[52] The line-item veto has since been ruled unconstitutional. Presciently, an unforgiving Senator Moynihan—who wondered why it was that at "no point in the course of those deliberations [with the administration or House over the Balanced Budget Act of 1997] did the subject of the Medicaid waiver come up" —warned the President that he chose poorly for the test case of his new executive authority (*Congressional Record—Senate* 1997: S8725). Moynihan explained that because the president's chose to exercise his new executive privilege "on a measure designed to help New York surely there will now be a lawsuit that will persuade the Supreme Court to strike down the measure as unconstitutional" (*Ibid*: S8726). Within a year the Supreme Court ruled in *Clinton v. City of New York* (1998) that the line item was veto unconstitutional.

effectively raise the state's federal share, thereby making the state's commitment to Medicaid sustainable (Congressional Record—Senate 1997: S8725). No doubt singling out Arkansas' generous FMAP rate because President Clinton previously served as the state's governor, Senator Moynihan slyly added how New York's dependency on the DSH payments would be lessened, "if, for example, the Federal Government paid 73 percent [of New York's Medicaid costs] as it does in Arkansas" (*Ibid*).

As a rebuttal to the President's rationale for his veto that the recusal amounted to preferential treatment of New York, Senator Moynihan cited a 1994 address given by President Clinton to a New York audience in which the president himself acknowledged, "There's no question that the formula should be changed, and that states like New York with high per capita incomes but huge numbers of poor people are not treated fairly under a formula that only deals with per capita income" (*Ibid*: S8726). The senator argued that until such time as a full reform of the funding formula could be undertaken, there was a need for exceptional ad hoc solutions, like DSH payments, to adjudicate certain states' unique fiscal situations.

Ironically, the Balanced Budget Act of 1997 included other examples of "preferential treatment" not vetoed by the president. The District of Columbia, for example, had its federal match permanently increased to 70 percent. Significantly, Alaska too had its FMAP amended, with its congressional representatives successfully arguing that its federal matching rate should reflect the reality that the state's cost of living was well above the national average. As a result, the Balanced Budget Act included an increase to Alaska's federal match from the bottom rate of 50 percent to the national average of 59.8 percent for the next three fiscal years. Alaska succeeded in having its own preferential FMAP rate extended for another five years in 2000.[53]

[53] Whereas the 1997 legislation had awarded Alaska with a fixed FMAP rate of 59.8, the Benefits Improvement and Protection Act of 2000 adjusted the FMAP formula to reflect Alaska's high cost of living by dividing the state's per capita income by 1.05, effectively raising its income relative to the otherwise unadjusted national income. With

The Hawaiian delegation also asked the House to include an increase in its FMAP to reflect its similarly high cost of living, but by then the bill had been closed for new amendments (Congressional Record—Senate 1997: S8726). Then despite the precedent set by Alaska and an explicit recognition in the Balanced Budget Act of 1997 that both Alaska and Hawaii's poverty guidelines (as they related to the new TANF program) should be calculated differently than in the continental states, the Hawaiian delegation was unable to secure an adjustment to Hawaii's FMAP to "reflect more fairly the state's ability to bear its share of Medicaid payments."[54]

No floor statement, no committee report, no media report could be found to rationalize what amounted to a legislative earmark granting special treatment to Alaska. Meanwhile, Hawaii's FMAP remained at 50 percent. In not reintroducing their appeal for a higher FMAP rate beyond the 106th Congress, it appeared that even the Hawaiian delegation had no illusions that their colleagues would be sympathetic to their state's specific fiscal imbalance.

Nonetheless, the different treatment of Hawaii and Alaska is astounding for two reasons. First, if the cost-of-living argument legitimating Alaska's special federal match is considered, the different fate of Hawaii is inexplicable because the nominal income data used in the current funding formula disadvantaged Hawaii more so than Alaska. For example, measured in real terms Hawaii was ranked as 48th poorest state in 1999 with an adjusted per capita income of $22,870. Comparatively, Alaska was ranked 33rd with a real per capita income of $25,606. The national average was $28,518. Adjusting Hawaii's FMAP to reflect the real value of the state's per capita income would have raised Hawaii's federal share about 20 points, from

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Alaska's special FMAP rate increasing to 60.1 percent in fiscal year 2001, compared to the 56.0 percent it would have fallen to with no adjustment, the CBO anticipated the added cost of the provision to be $200 million over the 5 years (CBO 2001).

[54] Senator Akaka introduced S. 1376 and S. 264 in the 105th and 106th Congresses, respectively, to increase the FMAP for Hawaii to the national average of 59.8 percent. His state's House delegation introduced similar bills in their chamber (respectively, H.R. 3118 and H.R. 402).

the national minimum of 50 percent to approximately 70 percent. A confounded Senator Daniel Akaka (D, Hawaii) summarized the situation for colleagues. "The same factors justifying an increase for Alaska apply to Hawaii," he said (Congressional Record—Senate 1999 Vol. 145(9): S792).

Second, as Senator Moynihan was always want to remind his colleagues with respect to New York, this modest correction to Alaska and Hawaii's comparative income data ignores the fact that latter had a comparatively higher poverty rate than former—Hawaii had a 17 percent poverty rate in 1998 compared to Alaska's 12 percent poverty rate and a national average of 14 percent (Leonard and Walder 2000). It could be reasonably expected that Hawaiians would have a higher tax burden with respect to the welfare needs of its residents compared to Alaskans.

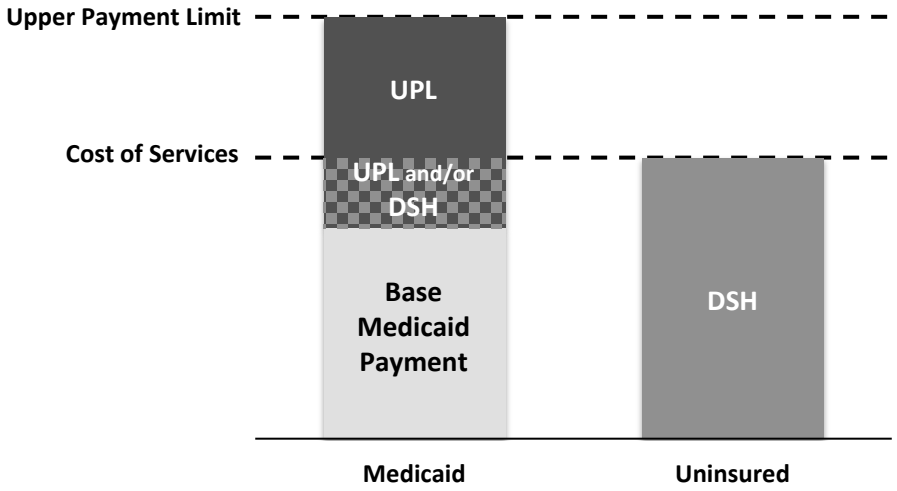
Upper Payment Limits (UPL)

Just as Congress and the executive were getting a handle on DSH abuses in the second half of the nineties, the states discovered that the Upper Payment Limit (UPL) (42 C.F.R. § 447.272 and § 447.321) could similarly be used to leverage federal financial participation far above the states' nominal, statutory federal match. The fiscal mechanism for UPL payments is essentially a variant of DSH payments, though for the most part intergovernmental transfers between local governments and the state are used in lieu of provider taxes and donations. Unlike DSH payment programs, states are not specifically required by federal law to implement a UPL program.

Whereas DSH payments are intended to subsidize the uncompensated care provided by hospitals to Medicaid and uninsured patients, UPL payments are meant to supplement the potential inadequacy of Medicaid's reimbursement rates in one of three types of facilities: hospitals, nursing homes or mental health

facilities. Medicaid DSH payments are excluded from the UPL calculation (though UPL payments made to a hospital count toward the hospital's DSH cap, reducing the total amount of DSH payments the hospital may receive). **Figure 5.5** is a visual representation differentiating the two types of supplementary payments.

Figure 5.5. Differentiating Medicaid's Supplemental Payments: UPL & DSH



Source: National Association of Public Hospitals and Health Systems

Although federal Medicaid law gives the states broad discretion in setting provider payment levels—so long as total payments are consistent with "efficiency, economy, and quality of care and are sufficient to enlist enough providers" (Section 1902(a)(30) of Social Security Act)—it does set an upper payment limit on reimbursements, which stipulates that Medicaid payments for fee-for-service care cannot exceed what would have been paid under Medicare's payment principles. In 1987, the Secretary of HHS issued regulations that interpreted this to allow states to supplement their normal vendor payment that fell below this UPL with lump sum payments equivalent to the difference between what the state paid in vendor payments to a specific class of facilities (hospitals, nursing homes, or mental health facilities) and what Medicare would have paid to those facilities (52 *Federal Register* pp. 28141-28148). Because most states typically set Medicaid reimbursement rates well below Medicare rates, this creates the potential for

significant "room" under the UPL capitation for the state to make supplemental payments. UPLs are eligible for the same federal financial participation as normal Medicaid vendor payments and the resulting federal transfers come with no stipulations regarding their use.

Similar to the Medicaid maximization schemes involving DSH payments of a decade earlier, Timothy Westmoreland, a director of Medicaid in the HCFA, reported in 2000 that "the practical outcome" of the UPLs "is that the States using this financing mechanism actually gain Federal matching payments without any new State financial contribution" and with "many States allowing their county-owned providers to keep *less than five percent* of the Federal funds that are used to provide these excessive payments" (Westmoreland 2000, emphasis added). He informed Congress upon how states were using UPL arrangements for non-health purposes, such as financing budget deficits or tax cuts, reducing state debt, and paying for education programs. "These practices, which are effectively general revenue sharing, are inconsistent with the Medicaid statute, Congressional intent, and Administration policy," summarized Westmoreland (*Ibid*).

For example, imagine a state's Medicaid typical reimbursement rate per hospital discharge was $1,000 less than what the state estimated would have been paid according to the customary Medicare payment schedule. If the state discharged 100,000 Medicaid recipients from hospitals in the fiscal year, the total UPL allowance for hospitals would be $100 million. The state could distribute the entire $100 million to local government-owned public hospitals (regardless of what proportion of Medicaid patients had their care provided by these specific hospitals). As usual, the federal government would reimburse the state a share of the UPL payment according to the state's FMAP rate; if the state had a FMAP of 50 percent, the state would receive $50 million from the federal government. Then the local governments would transfer some proportion of the supplementary payments originally paid by the state to the hospital back to the state. If the local government retained just 5 percent, or $5 million, thereby returning $95 million of the

original $100 million UPL payment back to the state, the state would net $45 million in additional revenues from the completed transaction.

Despite the obvious incentives of this funding arrangement and the fiscal convenience provided by intergovernmental transfers as their primary financing mechanism, UPL payments totaled just $313 million in fiscal year 1995. States only began to broadly implement UPL programs beginning in the late-nineties, after the Balanced Budget Act of 1997 (P.L. 105-33) repealed the Boren Amendments (Section 1902(a)(13)(A) of the Social Security Act) that required Medicaid payment rates be sufficient to cover the cost of "efficiently and economically operated facilities." By granting the states far greater freedom in setting payment rates, the states lowered their reimbursements, thereby worsening the disparity between the states' Medicaid payments and Medicare's payment schedule.

The resulting increase in the state's potential UPL allowance, as well as the concurrence of renewed Medicaid inflation and decreased real value of DSH payments, provided both the means and motive for the subsequent explosion in UPL payments. Between 1998 and 2000, UPL payments increased from $1.4 billion to $10.3 billion with the number of states having a UPL program increasing from only 12 states to 28 states. The growth in UPL payments accounted for nearly 30 percent of the growth in total federal Medicaid spending over 2000 (Schneider and Rousseau 2002).

As a result of the proven allegations of general revenue sharing and the appearance of fiscal impunities, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (H.R. 5661; as incorporated into The Consolidated Appropriations Act, P.L. 106-554) included proposals by the Clinton administration to curtail UPL abuses. Before these regulatory reforms were implemented the states were able to generate very high federal payments in part because they could combine, or aggregate, UPLs across private and public facilities into the calculation of the state's net UPL and then

direct the entire allocation to just the public facilities (who could be counted upon to reliably transfer the money back to the state). A government audit that examined how 6 states used intergovernmental transfers to finance UPL payments in 2000 was damning of the state's Medicaid maximization practices: the supplemental payments were not based on cost of provided care to Medicaid beneficiaries, the states used intergovernmental transfers to attain federal matching funds without contributing the required non-federal share, and the windfall federal revenues were used as general revenues that were as likely to be spent on education or infrastructure as healthcare (U.S. Dept. of HHS, OIG 2001). The Inspector General suggested that any portion of the federal share retained by the state government constituted, at the very minimum, "refunds required to be reported as other collections and, consequently, offset against expenditures reported to the Centers for Medicare and Medicaid Services" (Ibid: ii).

New regulation, promulgated just before President George W. Bush took office in 2001, broke up each group of providers based on the facility's ownership (state, local public, and private) so that any potential revenue shortfalls in Medicaid payment to private facilities could no longer be factored into determining the UPL paid to public facilities (66 *Federal Register* 3148 (2001)). The CBO anticipated the new regulation would "reduce states' ability to generate additional federal funds through UPL mechanisms by 95 percent for nursing homes and about 33 percent for hospitals" (CBO 2001: 17).

Significantly, however, the regulatory reform allowed the state to pay non-state, but still publicly owned, facilities up to 150% of the Medicare payment rate. This higher payment standard effectively nullified the intended affect that separating the facilities by ownership was to have on reducing the aggregate UPLs available for public facilities. President George W. Bush's first director of CMS, Tom Scully, characterized the separate 150 percent UPL as "the single biggest outrage I have ever seen in the history of government finance" (Riccardi 2001). The director swiftly eliminated the higher payment rate as "part of [the Bush] Administration's efforts to *restore fiscal integrity* to the Medicaid program and reduce the

opportunity for abusive funding practices based on payments unrelated to actual covered Medicaid services" (7 *Federal Register* 2602 (2002)).

In 2007, the Bush administration published additional regulation further affecting UPL payments. A new "Medicaid Cost Rule" again lowered the state's potential UPL payment, this time by instructing states that the determination of the upper payment limit that governmentally-operated health care providers could be reimbursed was not to exceed the cost of providing Medicaid covered services to Medicaid recipients (as opposed to the more generous payment determination used for Medicare). The regulatory changes also restricted certain intergovernmental transfers, and reaffirmed that all health care providers received and retained the total computable amount of their Medicaid payments (UPL, DSH or otherwise).

A 2008 federal court, however, vacated the regulatory change, after it was proven that the executive action violated a Congressional moratorium (one signed into law by President Bush) on the finalization of the regulation that would have implemented the Medicaid Cost Rule. Subsequent congressional laws extended the delay, and then rejected, the proposed regulatory change to UPL determination.[55]

Unfortunately, providing an accurate historical accounting of the total spending on these supplemental programs is difficult (the data for 1998 and 2000, above, was from survey of states, not HCFA/CMS reports) because the states do not separately report their non-DSH payments. Since 2001, CMS has required states to report certain supplemental payments on a separate informational section of

[55] See *Alameda County Medical Center, et al.* v. *Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services, et al.,* 559 F. Supp. 2d (2008)). The District Court referenced The Troop Readiness, Veteran's Care, Katrina Recovery and Iraq Accountability Appropriation Act of 2007 (P.L 110-28) as preventing the rule Subsequent to the court decision, Congress extended the moratorium on finalizing the "Cost Rule" to April 1, 2009 in Section 7001 of the Supplemental Appropriations Act of 2008 (P.L 110-252) and then expressed the sense that the Cost rule should not be adopted as a final rule in Section 5003(d) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5).

their expenditure reports (CMS 64.9I form), but states do not receive federal reimbursement based on this section of the expenditure reports and so the data is incomplete. The GAO, to the best of their abilities—that they admit, "likely understates" the true amount by several billion dollars—estimated that DSH and UPL supplemental payments totaled at least $23.4 billion in fiscal year 2006 (about $25 billion in 2008 adjusted-dollars)—$17.1 billion in DSH payments and $6.3 billion in UPL payments (GAO 2009: 21-22).

The Center for Medicare and Medicaid Services is critical of potential Medicaid maximization mechanisms, such as UPL and DSH payments. These supplemental payment programs have been historically susceptible to abuse and the fungible nature of state budgets makes them difficult to monitor once the payments are transferred to state accounts. This allows states to inappropriately leverage federal Medicaid matching dollars without necessarily making a corresponding contribution from their own revenue sources. If, as in the two hypothetical examples above, the DSH and UPL payments were essentially offsetting ledger entries in the state and local governments' bank accounts (and, therefore, did not actually go to reimbursing hospitals for either uncompensated care or Medicaid deficits), the supplemental payment arrangements threaten to violate the integrity of the federal/state partnership under Medicaid.

A few studies have examined how the state funding of these supplemental payments have affected the statutorily defined financial partnership between the federal government and the states and increased many states' effective federal matching rate (Coughlin and Zuckerman, 2003; Coughlin et al., 2007). For example, the average Medicaid federal matching rate among 20 survey states was approximately 57 percent in 2005; however, when the authors excluded provider taxes and all intergovernmental transfers from county funds, then the federal share of the real spending on supplemental payments rose 20 percentage points to nearly 87 percent. Further, seven of the twenty states were dependent on sources other than state

general funds for at least 95 percent of the state share of the supplemental payments (Coughlin et al. 2007: 1476-78).[56]

Dennis Smith, a CMS director, who, in testimony before the House, defended the Bush administration's regulatory changes to the UPL payments in 2007, argued that regulating supplemental payment programs was necessary because, absent corrective measures, Medicaid had the potential to be "a limitless account for State and local programs and agencies to draw Federal funds for non-Medicaid purposes" (Smith 2007). Numerous reports by the non-partisan GAO have concluded similarly, (see GAO 2000, 2001, 2004a, 2004b, 2005, 2006, 2008, 2009). Although the worst purported "Medicaid scams" by the states have been mitigated and it can be safely assumed that most of the tens of billions of dollars that go to these enhanced payments every year are in fact critical to the nation's safety net institution, a GAO report, published in 2009 maintained, "ongoing federal oversight of payments to offset uncompensated hospital care costs is warranted" (GAO 2009).

[56] It should be footnoted, at the very least, that Coughlin et al. do not level the explicit charge that the states are shirking their financial obligations. This is important to clarify. In many states, the county and local governments have traditionally contributed to Medicaid's costs. Since its inception, Medicaid has always permitted states to rely on local governments as a source of financing for the program. Indeed, the statute refers only to the federal share and the "non- federal share" of Medicaid expenditures (nowhere does the term "state share" appear) and the statute explicitly permits states to derive up to 60 percent of the non-federal share of Medicaid from "local sources" other than state general revenues. According to the National Association of Counties, 27 states required some form of local financial matching requirements for Medicaid in 2010. The funding mechanisms are varied. The counties' fiscal liabilities may be collected as a fixed amount or as a proportional share of certain Medicaid expenditures—ranging from a maximum of 10 percent of the non-federal share of the administrative costs in Ohio, to, $6.7 billion, more than one-third of the entire non-federal share, in New York (National Association of Counties, 2010).

With respect to the enhanced payments associated with UPL and DSH, the local facilities, whether public or private, are the entities that have the incentive to provide the necessary intergovernmental transfers or donations required to fully fund the supplemental payment programs. It is as much a means for the community hospitals to derive additional revenues to finance their operating budget at no net cost than it is for the state to increase its general revenues.

Block Granting a Medicaid Expansion: The State Children's Health Insurance Program

Although Republicans had introduced a revised Medigrant proposal again in 1996 (see Chapter 4 above), Secretary Shalala reasserted President Clinton's concern with the proposal (Shalala 1996) and the Republicans ultimately abandoned their efforts to reform Medicaid. With the public and politicos' attention largely diverted to welfare reform (and the upcoming general election) neither the Republican's Medigrant plan nor the National Governors' Association's alternative block grant proposal,[57] gained traction in Washington. Medicaid reform had temporarily moved to the periphery as Congress focused its attention to major welfare reform.[58] "For Medicaid, the year 1996 was almost a non-event," summarized David Smith and Judith Moore (2008: 243).

In 1997, however, Congress passed the State Children's Health Insurance Program (CHIP). It represented the first major expansion of public health insurance for the poor since the last of the Medicaid-related mandates passed in 1990. Included as an amendment to the Balanced Budget Act of 1997 (P.L. 105-33) and enacted as Title XXI of the Social Security Act, CHIP was a block grant that offered generous matching grants to the states to provide health-care insurance to children in families with incomes earning

[57] The National Governors' Association unanimously endorsed a repeal of the individual entitlement to Medicaid and its replacement with a combination of a block grant and, significantly, supplemental payments (not subject to congressional authorizations) for unexpected increases in enrollment. Ironically, the conservative Heritage Foundation was reticent to endorse the governor's block grant plan, being suspicious of the included supplemental "umbrella insurance" (Liu 1996); while, the liberal Center on Budget and Policy Priorities supported the NGA's plan, despite its strong opposition to the Republican's own Medigrant proposal (Lambrew 2005). Although Secretary Shalala testified "the Governors' financing mechanism had the potential to be creative and a workable formula that constrains growth without providing incentives to drop coverage," neither the Democrats nor Republicans were choose to take up the proposal in Congress (Shalala 1996).

[58] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (P.L. 104-193), was the landmark, bipartisan legislation that repealed the six-decade old AFDC program and replaced it with Temporary Assistance for Needy Families (TANF). Although Medicaid financing was not directly affected by the fundamental restructuring of the nations' welfare system, TANF did create some confusion over the enrollment status of Medicaid's "categorically" eligible AFDC recipients. Any decline in Medicaid enrollments, particularly among mothers and children, however, was unintended and temporarily.

between 150% and 200% of the federal poverty line, well above the existing maximum Medicaid thresholds. States could implement CHIP by expanding their Medicaid program, creating a separate CHIP program, or proposing a combination of the two approaches.

Unlike Medicaid, CHIP does not guarantee an individual entitlement and so children have no legally enforceable rights to benefits if a state runs out of money. Instead, CHIP funds would be available through a federal-state matching arrangement with the federal government's financial commitment purposefully capped. The original legislation authorized $40 billion in federal matching funds over 10 years, to be ostensibly financed by an increase in the federal tax on tobacco products. (Although CHIP attracted bipartisan support from some of the very legislators who had signed the Contract with America, it is unlikely that this significant increase in net federal spending was what Speaker Gingrich had intended when he proposed his block grant as a way to *shrink* the net size of the federal government.)

Despite not having the same open-ended entitlement status of Medicaid, CHIP was generously funded, with each state's funding allocation to be based on the number of low-income children and low-income uninsured children in the state, adjusted for the local cost of providing health care services. Any unspent funds under an individual state's original allotment could be carried over for two years (this was later adjusted to three years), after which time the remaining revenues, if any, would be redistributed to states who had overspent their allotments.

Similar to the proposed increase to the FMAP included in the Republican's Medigrant proposal, the federal government would distribute CHIP funding, up to the maximum allocation, as a matching payment according to an "enhanced" FMAP (E-FMAP). The E-FMAP (not to be confused with Senator Moynihan's proposed "Equitable FMAP" formulary, discussed below) provides greater federal assistance compared to the standard FMAP. It is calculated by reducing the state's Medicaid share by 30%. For example, for states

with the minimum standard FMAP of 50%, their state share decreases from 50 percent to 35 percent (50 - 50 × 0.30) and their enhanced FMAP rate is increased to 65 percent. The relative change is less for a poorer states with a high FMAP and a correspondingly lower state share to begin with: for example, Mississippi with a FMAP rate of 76.8 percent in 1999 would benefit from an E-FMAP rate of 83.8 percent, equivalent to a 9 percent increase over its baseline rate.

As it had done on multiple occasions in the past, Congress could have simply passed a reform that gave the states the option (or imposed upon them a mandate) of raising their eligibility criteria for children. Instead, by pairing the expansion with a significantly increased financial incentive Congress was effectively acknowledging the inadequacy of Medicaid's status quo funding arrangement. CHIP's enhanced FMAP established the precedent that any further expansion of Medicaid would require a reduction in the states' comparative fiscal burdens.

Although CHIP funding is ostensibly capped, the supplementary matching rate authorized for CHIP has the potential to be a major inflationary stimulus for public health spending and enrollments. Critical of this CHIP expenditure creep, the conservative Cato Institute lamented, "[T]hat cap is not as binding as it may appear" (Cato 2009: 138).

Certainly, the state and federal financial data backs this specific criticism: with the allocated appropriations running short of several states' full fiscal needs Congress appropriated an additional $283 million in FY 2006 and another $650 million in FY 2007 to be split among the several states that expected to run out of CHIP money before the end of the fiscal years.[59] It is not incidental that many of the states that required additional appropriations had taken the enhanced FMAP rate to expand eligibility well beyond the original intention of the 1997 law.

[59] Appropriations included as amendments to the Deficit Reduction Act of 2005 (P.L. 109-362) and U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007" (P.L. 110-28)

With CHIP set to expire in 2008, the 110th Congress took up its extension in 2007. By then CHIP had insured 7.1 million children (with an average point in time coverage rate approximating 4 million children). The proportion of children aged 18 and under who were uninsured dropped by about half between 1998 and 2007, from 28 percent to 15 percent (Kaiser Commission on Medicaid and the Uninsured 2009). The proposed reauthorization would have increased CHIP's then-current spending level of $5 billion per year by an additional $35 billion over the 5 years (to be paid for with a further increase in the federal tobacco tax), with the additional revenues permitting states to expand coverage to children in families earning up to 300 percent of the federal poverty line.

President George W. Bush twice vetoed the proposed expansion of CHIP in 2007. In his veto message the president reiterated his support for CHIP's reauthorization, but not its significant expansion as proposed by Congress. He argued that Congress' proposal would needlessly lead to government coverage displacing private health insurance for many children. "If this bill were enacted, one out of every three children moving onto government coverage would be moving from private coverage," rationalized President Bush in his first veto message (Bush 2007).

President Bush added that although CHIP was intended to target poor children, many states used the enhanced funding to expand insurance to children in families who earned more than twice the poverty line. Indeed, by 2007, 20 states had acquired Section 1115 waivers (albeit, with the tacit approval of President Bush's own Secretary of Health and Human Services) to extend CHIP coverage to children in families earning over 250 percent of the federal poverty line and in a few cases the parents of those children (Baumrucker 2008). Nina Owcharenko at the Heritage Institute sympathized with President Bush. "The debate is not about reauthorization. It is about expanding the government program," she explained (Owcharenko 2008). Given the magnitude of the proposed expansion to CHIP, the Heritage scholar's critique of the congressional debates over CHIP proved not unwarranted.

In January 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3). Although the contentiousness of CHIP's reauthorization moderates the perspective that CHIP was a bipartisan triumphant, its reauthorization still passed with an uncharacteristic level of bipartisan support: in the House 289 to 139, with 40 Republican offering their support, and in the Senate 66 to 32, with 8 Republicans joining the Democrats. (Colleen Grogan and Elizabeth Rigby (2009) offer an excellent account of the shifting partisan politics of CHIP over its first decade.)

The law increased annual CHIP allotments to the states by almost a factor of two, authorizing $79 billion in CHIP funds to be distributed to the states over the next five years. This included $25 billion in existing 'baseline' funding and $44 billion in new funding—nearly $10 billion more than the bills passed by Congress in 2007. Tellingly, the "State" was dropped from the bill's title and the colloquial S-CHIP acronym.

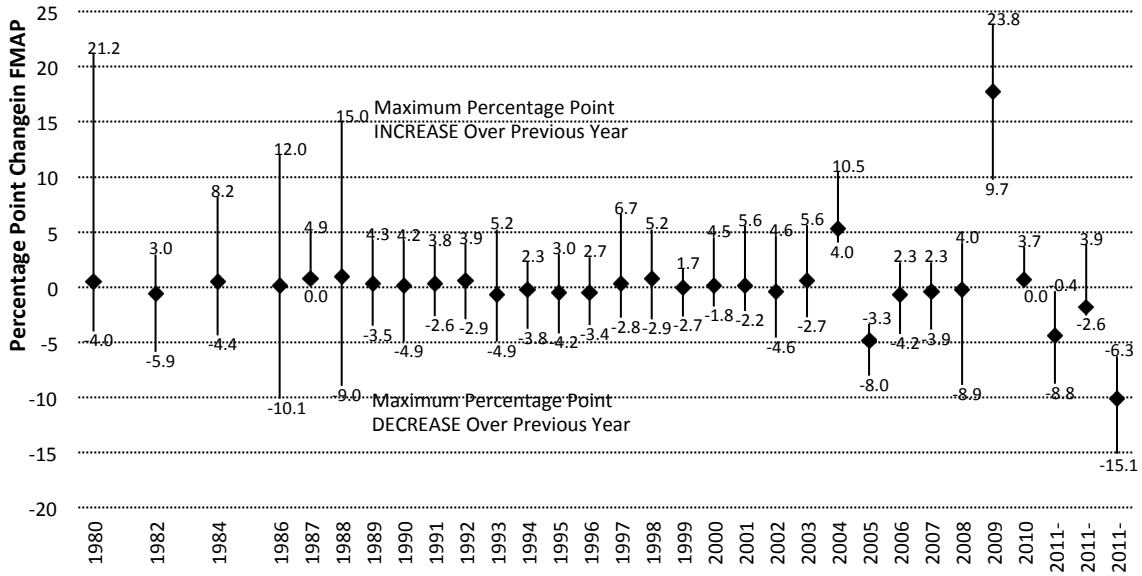
The law retained the Enhanced FMAP, but the allotment formulary for CHIP was adjusted to better take into consideration demographic trends and health care inflation. In fiscal year 2009 all states experienced an increase in their allotment, determined by the higher of either the previous year's federal allotment to a state, or the state's actual spending on SCHIP-eligible recipients, adjusted by for health care inflation and demographics.

Mitigating Medicaid's Burden by "Temporarily" Increasing the Federal Participation

Although a source of constant intergovernmental tension, Medicaid financing has always been predicated on a general belief that the states and federal governments should share in the financial

responsibility of providing health services to the poor. Based on the squared ratio of a state's per capita income to the national per capita income the Federal Medical Assistance Percentage defines the specific fiscal relationships between any particular state and the federal government with a state's FMAP being determined by the relative variability of the states' incomes. The mean FMAP rate has consistently hovered around 60 percent over the decades, but each states' specific FMAP rate will fluctuate as the relative incomes of the states changes. **Figure 5.6** presents the mean and max percentage point change in the FMAP rates from year-to-year. During normal economics periods a state could see its FMAP rate change by as much as ±3 percentage points. Wealthier states that are protected by the minimum rate of 50 percent are the least likely to be affected one way or another so long as their income remains well above the national mean.

Figure 5.6. Percentage Point Change (Mean, Max/Min) in FMAP Rates, FY1980-2011



Note: Max change excludes statutory revision to the District of Columbia's FMAP in 1997 (from 50 percent the year before to 70 percent) and Alaska's FMAP in 1998 (from 50 to 59.8)

Sources: Federal Register, Various Years; Authors Dataset

However, due to its construction, the FMAP is largely unresponsive to both national economic trends and abrupt changes in a state's fiscal conditions. Two aspects of the FMAP formula diminish its effectiveness at responding to countercyclical fiscal strains. First, the FMAP is based on an average of the previous three years' income data available from the Bureau of Economic Analysis. However, due to delays in economic reporting and the requirement that rates be published the prior fiscal year, the data used to calculate the FMAPs is already dated by the time the FMAP rates take effect—for example, the rates for FY2010 (that goes from October 2009 through September 2010) were published in November 2008, based on data from 2005-07. In 1986, the publication of FMAPs was accelerated from a biennial to an annual basis, with the FMAP being published sometime in October or November for the subsequent fiscal year.

Further, because the FMAP formula is based on a ratio of state incomes to the national average, if all, or nearly all, states experience lower economic activity, the ratio between these to numbers may remain essentially unaffected or bare little relationship to national economic trends. Irrespective of any nominal decline to state-level personal incomes, a state with a per capita income equivalent to the national median will still be reimbursed 55 percent of their Medicaid costs. Only the comparatively worse off states would see any potential increase in their federal share, but only then after several intervening years given.

The significant lag in the income data used, the averaging of this data, and the endogeneity captured in the income ratio guarantees that the FMAP formula is incapable of adjusting to abrupt changes in economic conditions and will be largely unresponsive to national economic downturns.[60] With state

[60] For example, the baseline matching rates for FY 2009, having already been published in November 2007, are based on income data for 2004, 2005 and 2006. Significantly, the mid-decade was a period of relative economic prosperity in the United States: state-level per capita incomes increased an average of 4.9 percent annually and state revenues increased an average of nearly 10 percent annually. In contrast, in 2009, personal income declined 1.7 percent and state tax collections fell 8.5 percent in 2009, compared to the already depressed figures of the previous year (data from Bureau of Economic Analysis, U.S. Census Bureau, National Conference of State Legislatures). The impact of the economic downturn of 2009 will not begin to be even partially reflected in the FMAPs until FY 2012.

budgets increasingly dependent on the amount of their federal share to offset their aggregate Medicaid spending, these conditions could cause temporary, yet potentially severe, state fiscal crises.

Despite the inherent problems associated with the FMAP, Congress had not traditionally excused the states of their shared fiscal responsibility to provide Medicaid during recessions. With the possible exception of the apparent abuse by the states of DSH payments that raised state's effective FMAP rates (after discounting state spending by provider donations) and the subsequent abuse of such DSH payments during the early 1990s recession, the states' responsibility for the social welfare of their residents has held during economic recessions when the countercyclical nature of welfare spending exasperated the fiscal burden imposed on state taxpayers. Congress has not historically appropriated supplemental Medicaid payments to the states simply because of economic slowdowns: for example, neither during the 1973-75 recession when GDP fell 3.2% over 16 months and unemployment peaked at 9.0% nor during the recession of the early 1980s when GDP dropped 2.7% and unemployment reached 10.8% did Congress offer the states an increase in federal Medicaid assistance.

Yet, whereas Medicaid insured 18 million Americans and accounted for 8 percent of state revenues in 1973 and insured 22 million and accounted for 11 percent in the early 1980s, by 2001 the numbers were approaching 50 million and over 22 percent. Even during the extended period of economic prosperity that preceded the new millennia's recessions, state spending on Medicaid (and CHIP) was steadily crowding out other public commitments. Any precipitous drop in revenues would have a significant impact on a program such as Medicaid with countercyclical expenditures. Such was the case in 2009. For example, during the

first quarter of the year tax collections experienced the most significant drop then on record[61] at the same time that Medicaid experienced its largest one-year increase in enrollments.

Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L 108-27)

In 2003 with the economy rapidly deteriorating after the longest period of economic growth in US history, Congress felt compelled to react to the states' Medicaid-related fiscal crises. With GDP contracting by 0.3% over the latter half of 2001 and unemployment continuing to rise well after the overall economy improved, reaching 6.3% in June 2003, Congress and President Bush accepted that the states required federal assistance to meet Medicaid's unsustainable countercyclical demands.

To relieve some of the states' fiscal burden associated with Medicaid, the Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L 108-27) included $10 billion worth of temporary Medicaid assistance (along with another $10 billion in direct assistance apportioned to the states). The Medicaid provisions (1) held states harmless for any potential annual decline to their FMAP rate for the last two quarters of fiscal year 2003 and the first three quarters of fiscal year 2004 and (2) uniform increased every state's federal share by 2.95 percentage points for those 15-months. Receipt of the extra federal funding was dependent upon the states not restricting their eligibility criteria—none did.

In 1986 Congress had also included a hold-harmless provision when it accelerated the publication of the states' FMAPs,[62] but the intervening 15 years made its impact much more significant to the affected

[61] Boyd, Donald and Lucy Dadayan. 2009. "State Revenue Report: State Tax Decline in Early 2009 Was the Sharpest on Record." The Nelson A. Rockefeller Institute of Government (July 2009). Internet: http://www.rockinst.org/pdf/government_finance/state_revenue_report/2009-07-17-SRR_76.pdf

[62] The Consolidated Omnibus Reconciliation Act of 1985 (P.L. 99-272) accelerated the publication of FMAPs from a biennial to an annual basis with the funding rates being published sometime in October or November for the

states. Given Medicaid's high total costs, as little as a one-half to one percentage point drop in a state's FMAP (with larger changes to the state's matching percentages not being unusual) could have a significantly substantive impact on a state's overall budget. For example, between FY 2002 and FY2003 California's statutory FMAP rate dropped from 51.40 percent to 50.00 percent. Policy analysts' Vic Miller and Andy Schneider (2004: 2) estimated that this marginal 1.40 percentage point drop in the state's federal matching rate could have cost the state nearly half a billion in federal Medicaid payments. However, as a result of the combined effects of the hold harmless provision and the uniform increase to every state's FMAP, California saw its federal match temporarily increased to 54.35 for the second half of FY 2003 (instead of dropping to 50.00).

In addition to raising the FMAP rate, the law temporarily increased the state's DSH payment allotments for FY 2004, increasing them to 116% of the FY 2003 allotments and eliminating the cap that DSH payments could not exceed 12 percent of medical assistance payments (DSH payments, however, were not subject to the enhanced FMAP rate).

American Recovery and Reinvestment Act of 2009 (P.L. 111-5)

Again in 2009, with the nation in the worst recession since the Great Depression and state tax collections declining by 8.6 percent, Congress included an $86.6 billion authorization for increased Medicaid spending in its $787 billion stimulus bill—the American Recovery and Reinvestment Act of 2009 (P.L. 111-5). As was the case in 2003, to qualify for stimulus funds the states could not lower their

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subsequent fiscal year. Though this reform did not change anything in the fiscal arrangement between the states and the federal government, it is significant for highlighting one of the potential faults of the FMAP calculation. Before the change in computing the FMAP was set to become effective beginning in fiscal year 1987, the Omnibus Reconciliation Act of 1986 (P.L. 99-509) held twelve states fiscally harmless against a reduction of their matching rate that the new annual calculation affected for 1987.

eligibility criteria. (States, however, still retained the ability to cut optional Medicaid services—such as dental or home health care—or reduce provider payment rates to help offset the added cost of new enrollees, but few states did so and some states actually raised benefits.)

The legislation impacted the states' FMAP rates in three major ways. First, the law held states harmless for any decrease in their FMAP rates that resulted from economic gains in the year prior to the national recession. For example, if a state's FMAP rate in FY 2008 was 73% and scheduled to drop to 70% for FY 2009, then the state would retain its higher FMAP rate of 73% for the duration of FY 2009 and FY 2010, and for first quarter of FY 2011 (extended through FY 2011 through additional legislation). Second, the stimulus bill provided an across-the-board increase—6.2 *percentage point* rise for every state's base federal-share. Finally, the law raised the states' federal match by including a variable unemployment-related adjustment that reduced the state's adjusted *state-share* by up to 11.5 *percent*, depending upon the state's most recent quarterly unemployment rate in relationship to the national average. The supplemental federal match was to last 27-months, from July 2008 (retroactively paying the states for past reimbursements) through December 2010 (Families USA 2009).[63]

[63] An FAQ prepared by Families USA (2009), describes how the enhanced FMAP rate is calculated:
To determine the amount of additional assistance, you first have to determine how much the unemployment rate has risen. If a state's unemployment rate in any quarter between October 1, 2008, and December 31, 2010, exceeds the average unemployment rate in its base quarter by:

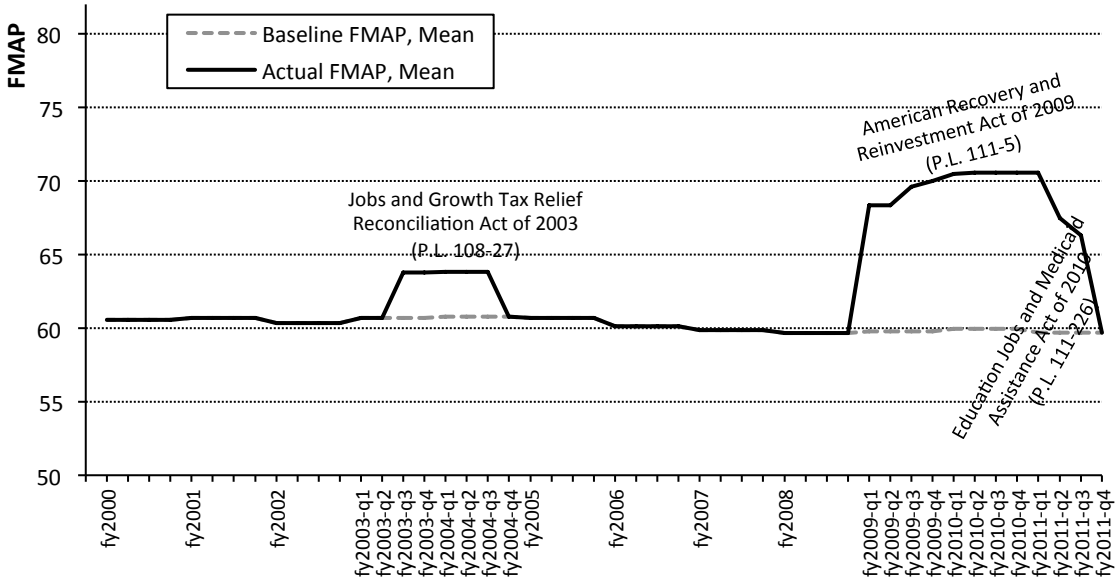
- 1.5 – 2.5 percentage points, the state's share of Medicaid will be reduced by 5.5 percent (Tier 1)
- 2.5 – 3.5 percentage points, the state's share of Medicaid will be lowered by 8.5 percent (Tier 2).
- 3.5 or more percentage points, the state's share of Medicaid will be reduced by 11.5 percent (Tier 3).

Once the tier of additional assistance has been determined, it is applied as follows:

1. apply the "hold harmless" provision to the state's FMAP
2. add 3.1 percentage points (representing one-half of the 6.2 point across-the-board FMAP increase)
3. figure out the corresponding state percentage (100 minus the sum in 2, above)
4. multiply the state percentage calculated in 3, above by the percent reduction shown in the appropriate tier of assistance, above. This is the amount of additional assistance the state will receive due to high unemployment.

Figure 5.7 presents the mean FMAP since 2001 to show how the temporary increases to the baseline FMAP rates passed by Congress in 2003, 2009 and 2010 affected the FMAP.

Figure 5.7. Impact of Congressional Legislation to Temporarily Increase Federal Share on Average FMAP rate



Sources: Congress passed following laws to temporarily raise FMAP rates thereby increasing proportion of Medicaid spending paid by federal government:

Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27)

- Medicaid FMAPs for the last two quarters of FY2003 and first three quarters of FY2004 were held harmless from annual declines and were uniformly increased by an additional 2.95 percentage points

American Recovery and Reinvestment Act of 2009 (P.L. 111-5)

- For a 9-quarter "recession adjustment period" that begins with the first quarter of FY2009 and runs through first quarter of FY2011, the ARRA holds all states harmless from any decline in their regular FMAPs, provides all states with a uniform increase of 6.2 percentage poitns, and provides an unemployment-related increase to qualifying states.

Education Jobs and Medicaid Assistance Act of 2010 (P.L. 111-226)

For example:

A state with an FMAP rate of 55 percent would normally pay 45 percent of its Medicaid costs. Once 3.1 percentage points are added (55 + 3.1 = 58.1), the state percentage would be 41.9 percent (100 – 58.1 = 41.9). If the state qualifies for the first tier of additional assistance, the 5.5 percent reduction of the 41.9 percent state share would amount to 2.3 percentage points (41.9 x 0.055 = 2.3). Finally, these 2.3 percentage points would be added to the federal share of Medicaid after the hold-harmless and 6.2 percentage-point increase have been applied:

55.0	Current FMAP
+ 6.2	Across-the-board increase
61.2	Subtotal
+ 2.3	Additional assistance for high unemployment
63.5	New FMAP

- Provides an additional six-month increase to FMAPS for second and third quarter of FY2011 (through until June 30, 2011-the end of most state fiscal years). Maintains hold-harmless provision and unemployment-related bonus, but reduces across-the-board increase from 6.2 percentage points to 3.6 in second quarter of FY2011 and 1.8 percentage points in third quarter of FY2012.

The need for these complicated adjustment to the states' federal share helps to highlight how the FMAP formula fails to accurately reflect the changing capacities of the states to finance their Medicaid commitments. For example, without the temporary enhancement to the FMAP, the matching rates for FY 2009—having already been published in the *Federal Register* in November 2007—would have been based on the income estimates for 2004, 2005 and 2006. The FMAP formula would not have incorporated the impact of the national recession until FY 2012. Significantly, these three years was a period of relative economic prosperity across the United States: annually, state-level per capita incomes increased an average of 4.9 percent and state revenues increased an average of nearly 10 percent. In contrast, in 2009, state personal income declined 1.7 percent and state tax collections fell 8.5 percent, on average, compared to the previous year (Bureau of Economic Analysis, Various Years; U.S. Census Bureau, 2010). Were it not for the hold-harmless provision for the states' FMAP rates included in the 2009 stimulus bill, 17 states would have seen their FMAP rate decline for fiscal year 2009 compared to the previous year (Baumracker 2010).

Table 5.1 compares the original FMAP rates for FY 2009, published in the *Federal Register* in 2007, to a hypothetical FMAP calculation based exclusively on the states' actual 2009 per capita income. Despite the considerable worsening of the fiscal situation facing the fifty states in 2004-06 compared to 2009, the differences the actual and hypothetical calculations are minimal. Again, this is the result of the FMAP formula reflecting variation among the states' per capita income *relative* to the national average. If nearly all states experienced lower economic activities the ratio between the individual states' per capita income and the national average may remain essentially unaffected. Irrespective of the nominal decline in its economic

activity, a state with a per capita income equivalent to the national median will still be reimbursed 55 percent of their Medicaid costs.

Table 5.1. Federal Medical Assistance Percentage (FMAP), Actual FY 2009 versus Hypothetical FY 2009 (excluding impact of impact of ARRA)

State	Baseline FMAP FY2009	Hypothetical FMAP FY2009	Difference	State	Baseline FMAP FY2009	Hypothetical FMAP FY2009	Difference
Alabama	67.98	67.82	-0.16	Montana	68.04	66.03	-2.01
Alaska	50.53	50	-0.53	Nebraska	59.54	57.4	-2.14
Arizona	65.77	68.13	2.36	Nevada	50	56.28	6.28
Arkansas	72.81	70.02	-2.79	New Hampshire	50	50	0
California	50	50	0	New Jersey	50	50	0
Colorado	50	50	0	New Mexico	70.88	68.02	-2.86
Connecticut	50	50	0	New York	50	50	0
Delaware	50	53.43	3.43	North Carolina	64.6	65.13	0.53
Florida	55.4	58.07	2.67	North Dakota	63.15	54.09	-9.06
Georgia	64.49	66.47	1.98	Ohio	62.14	63.22	1.08
Hawaii	55.11	50	-5.11	Oklahoma	65.9	63.46	-2.44
Idaho	69.77	70.61	0.84	Oregon	62.45	62.63	0.18
Illinois	50.32	50	-0.32	Pennsylvania	54.52	53.98	-0.54
Indiana	64.26	66.59	2.33	Rhode Island	52.59	50.61	-1.98
Iowa	62.62	60.32	-2.3	South Carolina	70.07	70.29	0.22
Kansas	60.08	57.77	-2.31	South Dakota	62.55	59.92	-2.63
Kentucky	70.13	70.14	0.01	Tennessee	64.28	65.86	1.58
Louisiana	71.31	62.96	-8.35	Texas	59.44	60.9	1.46
Maine	64.41	60.33	-4.08	Utah	70.71	72	1.29
Maryland	50	50	0	Vermont	59.45	56.45	-3
Massachusetts	50	50	0	Virginia	50	50	0
Michigan	60.27	65.99	5.72	Washington	50.94	50	-0.94
Minnesota	50	50	0	West Virginia	73.73	69.50	-4.23
Mississippi	75.84	73.38	-2.46	Wisconsin	59.38	60.17	0.79
Missouri	63.19	62.61	-0.58	Wyoming	50	50	0

Sources: *Federal Register* (November 2007) and author calculations using state-level personal income data from BEA.

Consequently, even if the FY 2009 FMAP rates had been based exclusively upon the states' depressed income data from 2009, most states would have seen little or no respite in the share of total Medicaid spending that they remained responsible for financing. States such as Louisiana and Maine that despite having their own state revenues decline by 9.2 percent and 8.2 percent, respectively, would have actually seen their federal shares decrease. Overall, 22 states would have seen their FMAP rate fall, by an average of 2.75 percentage points (a number that does not include the 11 states that would have been protected from any decline in their FMAP due their to being subject protected by minimum rate of 50 percent). Alternatively, only 17 states would have benefited from using the more recent economic data, gaining an average of slightly less than 2 percentage points.

Education Jobs and Medicaid Assistance Act of 2010

When Congress passed ARRA in January 2009, unemployment stood at 7.6 percent. A report by the administration warned that without the government's stimulus the unemployment rate would peak at 9 percent in 2010; but with stimulus funding, unemployment should remain just below 8 percent (Romer, 2009). Unfortunately, the administration forecasts were overly optimistic. Even before the start of 2010 it was clear that with the continued deterioration of the national economy was affecting state revenues as well as Medicaid demand and therefore state expenditures. With the national unemployment rate now approaching 10 percent the rationale for the FMAP enhancements persisted and throughout 2010. Governors and state officials warned that without a continuation of the supplemental federal funding states would need to enact severe rescissions to Medicaid beginning in January 2011.

In February 2010 forty-two state governors signed a letter for the Congressional leaders requesting the "timely passage of an extension of ARRA's enhanced FMAP" and arguing that such legislation was

prudent and "would greatly assist [the states] in maintaining services and further stabilizing the economy" (nga.org 2/22/2010). While both the House and Senate had managed to separately pass a six-month extension of the full FMAP enhancement, the supplemental Medicaid funding was attached to Congressional bills that died or were stripped of the Medicaid-related provisions for one reason or another.[64] During the summer of 2010 the National Governors Association again lobbied Congress to argue, "passing a two-quarter extension of FMAP as soon as possible is the best way to help states bridge the gap between their worst fiscal year and the beginning of recovery." Given the countercyclical nature of Medicaid spending the governors' forewarned of "the role states play in either speeding recovery or prolonging the effects of a recession."

Not persuaded by the governors' pleas, Republican Senate Leader Mitch McConnell (R-Ken.) rhetorically asked, "When does this dependency [of the states on the federal government] come to an end?" Referring to original FMAP stimulus included in ARRA answered: "I thought last year was suppose to be timely, temporary, and targeted" (*Congressional Record—Senate* 111(2): S6680). In the House, Rep. Steve Buyer (R-Ind.) was similarly unsympathetic to the "great spin"—as he called it—of the governors and their states. "This is about protecting the ignominious conduct and behavior of legislators that didn't do their job and they're too frightened right now, 84 days before an election," Buyer exclaimed. "They don't want to increase taxes, they don't want to cut spending, and they don't want to monetize the debt.... This is a bailout. This is another bailout," he shouted (*Congressional Record—House* 111(2): H6614).

Despite such strident opposition, Congress managed to narrowly pass the Education Jobs and Medicaid Assistance Act of 2010 (P.L. 111-226) in August: the bill passed the Senate by a vote of 61-38 after the Democrats courted Republicans Olympia Snowe and Susan Collins to break a filibuster; and,

[64] A 6-month extension of the full 6.2 percentage point increase and unemployment adjustment was included in President Obama's FY 2011 budget. It had previously passed as an amendment to larger bills in the House on December 9, 2009, by a narrow vote of 217-212 and the Senate on March 10, 2010, by a vote of 62-36.

subsequently passed the House on a party line vote of 247-161. The final bill provided $26.1 billion in supplemental state aid—$16.1 billion for Medicaid as well as $10 billion in direct assistance to local school boards. The temporary extension of the Medicaid assistance was a compromise measure that reduced and then phased out the enhanced FMAP over six months, through June 2011—the end of most states' fiscal year 2011. Further, instead of a 6.2 percentage point increase, as was included in the original stimulus, the law increased the states' baseline matching rates by 3.2 percentage points for the first three months and 1.2 percentage points for the second three months (it however retained the variable unemployment-related adjustment to the state share).

As contentious as the political battle over the passage of this second state "stimulus" package was it was striking that the $16.1 billion FMAP extension was largely absent from public debate. The Democratic Caucus and the White House succeeded in what can only be perceived as a deliberate strategy of emphasizing the $10 billion education component and ignoring the Medicaid assistance.

Standing with teachers at the White House prior to the House's final vote on the bill, President Obama stressed the immediacy of the state's fiscal potential problem in terms of the upcoming school year. "We can't stand by and do nothing while pink slips are given to the men and women who educate our children or keep our communities safe," he said. To quantify the bill's urgency, the White House posted on its homepage an interactive map that detailed how many teacher jobs would be saved by state as a result of the legislation that the president championed as "an investment in our economic prosperity and in our children's future" (whitehouse.gov; Barnes, 2010). No comparable map showing the impact of extending the supplemental Medicaid assistance was produced.

In Congress, Senator Dick Durbin (D, Ill.) emphasized the necessity of the temporary measure to stave off state austerity and save teacher jobs and did not specifically mention Medicaid in his remarks that

kicked off the final hour of debate after the Democrats successfully invoked cloture on bill. Defending the budget neutrality of the legislation, Senator Durbin explained that the increased spending was a "conscious decision to move resources from other parts of the budget, where they are not as high a priority, into the priority of keeping teachers in the classroom" (S6678) Speaker Nancy Pelosi (D, Cal.), too, was similarly silent on the Medicaid provision in a press release her office released preceding the final vote on the bill, choosing instead to criticize Republican members of Congress for their "jaw-dropping indifference to America's teachers and police officers" (Pelosi, 8/9/2010)—a sentiment she would reiterate on the House floor. Curiously the congressional Republicans respected the Democrats' script. So too did the nation's media.[65]

Senator Lamar Alexander (R, Tenn.) was one of the few congresspersons that expressed concern specific to the extension of the FMAP extension. The senator had served two-terms as Tennessee's governor in the Eighties and so had direct experience with state-level Medicaid budgeting and has frequently been critical of the federal requirements on state Medicaid programs. He pointedly criticized the bill for mandating a continued maintenance-of-effort requirement that, as he put it, "says to the governors, 'Don't you change Medicaid. You're not even allowed, if you take this money, to make changes that would save money in Medicaid.'" The senator warned that the constraint against the states adjusting their eligibility criteria downward "ties the Governors' hands" and would only "extend the so-called fiscal cliffs in the states" (*Congressional Record* 111(2): S6565). But, Senator Lamar represented a small minority of concerns.

For the most part, the opponents of the bill continued to repeat their now well-rehearsed election year criticism of the Democrat's tax-and-spend policies and generally characterized the Education Jobs and Medicaid Assistance Act as a bailout to fiscally irresponsible states and an election-year pay-off to the

[65] That Representative Charlie Rangel (D-N.Y.) gave an emotional 30-minute floor speech against charges of ethic violations on the same date that the House returned from their August recess specifically to pass the Education Jobs and Medicaid Assistance Act, no doubt, deflected some of the public and media's attention from the bill.

Democrat's special interests—teacher unions. Senator Judd Gregg (R., N.H.) was direct in his criticism, describing that at its "essence" the bill was a "pay off education unions," emphasizing how "26 percent of the delegates at the Democratic National Convention were teachers, members of teachers unions" (*Congressional Record—Senate* 111(2): S6680). Medicaid funding was largely peripheral to a political narrative that pitted unionized public employees against federal bailouts for the states.[66]

In contrast to the teachers' unions lobbying efforts, the medical community was not attacked for its support of the bill; nor were congresspersons criticized for listening. "Our organizations stand ready to assist Congress in support of legislation to stabilize Medicaid at this critical time," announced the American Academy of Family Physicians, the American College of Physicians, the American Osteopathic Association and the American Academy of Pediatrics in a letter sent to every senator urging for their support of the extension of the enhanced FMAP provisions (aafp.org, letter of July 13, 2010). Separately, the American

[66] The *New York Times*, for example, reported, "The legislation would provide $10 billion to retain teachers who might otherwise lose jobs to cutbacks, and an additional $16 billion to help states struggling to close budget deficits." Adding, "The $16.1 billion in aid to states would increase the federal contribution toward Medicaid costs, allowing states to shift money elsewhere" (Herszenhorn, 2010).

Even conservative editorials that were generally critical of the supplemental state assistance directed their ire toward the bill's education component and not the more costly Medicaid assistance to the poor. The *Washington Post* criticized the $10 billion for education jobs as "deeply discouraging" and "more of an election-year favor for teachers unions than an optimal use of public resources." The paper acknowledged that "the same bill also includes $16 billion for Medicaid relief" that "defensibly helps states cope with what is, for many, a crushing federal mandate", but this was peripheral to the *Post*'s editors criticism of the education funding and the $11.9 billion reduction in nutritional assistance to the poor (Washington Post, 8/6/2010).

The conservative *National Review* also narrowly described the bill as a "$10 billion public-education bailout" to "the largest political contributor [the nation's teacher unions] to Congress" (Burke, 8/4/2010).

And the *Wall Street Journal* characterized the state aid as a "teacher bailout" that "comes with strings that will multiply the benefits for this core Obama constituency" (Wall Street Journal, 8/10/2010). In another editorial the *Journal* again myopically characterized the bill as a union bailout that "hands $10 billion to mainly unionized public employees, paid for by cutting benefits for the poor." The editors quoted the stalwart liberal, Rep. Rosa DeLauro (D, Conn.), who described the bill as a "bitter pill to swallow" and who compared her vote to "Sophie's Choice"—a hyperbolic reference a William Styron book about the decision forced on a mother by the Nazis as to which of her two children will live. "Rosa's choice was to help the unions first," assessed the *Journal* (8/12/2010).

Hospital Association directly lobbied for the extension. After the vote the Association released a statement to "applaud Congress and the Administration's action to help protect the health care safety net" (aha.org).

Federalizing of Medicaid

The Patient Protection and Affordable Care Act of 2010

On March 23, 2010 President Barak Obama signed into law the Patient Protection and Affordable Care Act ("PPACA", P.L. 111-148).[67] The significance of the near trillion-dollar[68] reform package (as budgeted for 2010-2019) cannot be understated. PPACA signified the first time since the enactment of Medicare and Medicaid in 1965 that Washington had successfully demonstrated its resolve to fundamentally reform the American health care system. At the bill-signing ceremony, a triumphant President Obama claimed health reform marked "a new season in America," adding: "We have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care" (The White House 2010).

Integral to the nation's new promise of enhanced health care security would be Medicaid. More than any other reform affecting Medicaid since its inception, PPACA greatly expands the poor's entitlement to health care. Accounting for over half of the 32 million Americans who will eventually become newly insured because of PPACA, the Medicaid provisions, including the state option to raise eligibility criteria to

[67] As amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)

[68] During the bipartisan "Blair House" health reform meeting in 2010 in February, Rep. Paul Ryan (R-Wisc.) challenged the administration's cost estimate and argued that that a more accurate accounting of the cost of the reforms, estimated for its second decade of implementation, would be significantly higher, at $2.3 trillion (although Rep. Ryan is more forthcoming about measuring certain costs, he ignores increased revenue streams and cost savings that will offset the growth in spending) (*Wall Street Journal* 2010).

133 percent of poverty for all Americans and the enhancement of reimbursement rates for certain primary care physicians, are the most expensive and the most expansive components of health reform.[69]

Yet, despite its importance to health reform, Medicaid was—as was the case in 1964 and 1965—the neglected partner during much of the contentious 2009-2010 health reform debates, its significance largely underestimated or ignored. Except for emphasizing some of egregious political compromises that were tied to federal Medicaid payments—such as, and among other backdoor deals, the aptly named "Cornhusker kickback" and "Louisiana Purchase" that the recalcitrant senators Ben Nelson (D-Neb.) and Mary Landrieu (D-La.) shrewdly lobbied to have included in the Senate's version of the bill, but were ultimately reconsidered in the subsequent reconciliation act—there was shockingly little media attention or even political scrutiny by elected officials of the impact that healthcare reform would have on the states' Medicaid programs.

While typical of the general silence permeating the fifty year history recounted above, the modern silence is notable because the Medicaid reforms were responsible for over half of the individuals who will gain health insurance coverage through PPACA and the nonpartisan Congressional Budget Office estimated that the Medicaid components would add $434 billion in outlays to the federal budget over the legislation's first decade—costing $97 billion in 2019, the last year of the CBO's prospective estimate. (Comparatively, the price tag of the premium and cost sharing subsidies for private insurance purchased through the new Health Insurance Exchanges was approximated to be $358 billion over the same decade—costing $88 billion in 2019) (Elmendorf 2010: Table 2). Whereas the costly implementation of Title XIX of the Social

[69] Certainly, the extensive new regulations on the private insurance market that are included in the health reform law will have some major and many subtle effects on the health care insurance purchased by almost all Americans and such consequential reforms warranted extensive scrutiny. These reforms may decrease profits and/or raise premiums, but by themselves they do not do anything to change the institutional arrangements of the private insurance private insurance market.

Security Amendments of 1965 caught most observers by surprise, the 111th Congress and its media watchdogs could not claim such rational ignorance of the cost of the Medicaid components of PPACA.

Beyond its absolute costs, PPACA transforms Medicaid policy in several ways. First, the liberalizing of eligibility rules will fundamentally change the demographics of Medicaid. Ever since its enactment Medicaid has served, almost exclusively, poor children, pregnant women and single mothers, as well as the indigent disabled and elderly; all of whom Americans have long accepted as sympathetically deserving of public charity given their general exclusion from the labor market. Medicaid has remained until now a program not for the poor generally, but for a specific "deserving" subset of the poor. Non-disabled adults, for the most part, have always remained excluded from accessing public health insurance. Only individuals who are excluded from employment for reasons beyond their own control—age, disability or childbearing responsibilities—have ever been deemed deserving of the public's charity. The recent health reforms significantly, if subtly, remove those maternalistic restrictions and reject the notion that employment is sufficient prerequisite having access to affordable health care. The Medicaid expansion will do more to diminish the prototypical maternalistic notion of welfare deservingness than any reform to the social welfare state since the 1960s. If the 1996 welfare reforms ended welfare-as-we-knew-it, then health reform will end Medicaid-as-we-know-it.

Second, the Medicaid reforms included in PPACA offer a potential backdoor for states and or regional partners to implement a public option by leveraging Medicaid's administrative structure. While the public, punditry, and politicians' were fixated on the paralyzing controversy surrounding a national public option, or lack thereof, PPACA included a significant Medicaid-related provision known as the Basic Health Plan that can be fairly accurately described as a quasi- or state-based public option. Offered by Senator Maria Cantwell (D, Wash.), the Basic Health Plan allows individual states, or compacts of states, to negotiate directly with private health insurers on behalf of its uninsured residents between 133 and 200

percent of poverty in order to establish plans that would be an alternative to the private health insurance exchanges.[70] A Basic Health Plan will not be dissimilar to the Medicaid managed care plans already offered in many states. States qualifying for a Basic Health Plan wavier will receive a direct federal transfer valued at 95 percent of the affordability tax credits and cost sharing reductions[71] that would have otherwise been provided to individual residents of the state who enrolled in the health plans offered on the national exchanges. The state would then negotiate rates with insurers and managed care organizations, paying for the services using a combination of the federal transfer payments, premium collections and deductibles.

Third, the Medicaid reforms continue the trend toward federalizing Medicaid financing. Barring any precipitous increase in the number of residents falling below the poverty line, the number of individuals enrolled in regular Medicaid—i.e. individuals eligible under the states' pre-2010 eligibility criteria—should remain relatively stable, as most new enrollees will gain Medicaid eligibility under the enhanced either through the provisions PPACA or the higher eligibility criteria of CHIP. The 100 percent federal match for newly eligible enrollees included in PPACA as well as the significant increases to FMAP that accompanied CHIP in 1997 and its expansion in 2008-09, means that most of the expenditures related to new enrollees

[70] In states that choose to institute a Basic Health Plan, all residents with household earnings between 133 and 200 percent of poverty line will be ineligible for the tax credits that would have otherwise been available to them to purchase private insurance. Beginning in 2017, states will be able to apply for a "Section 1332 Waiver for State Innovation" to expand their state's Basic Health Plans beyond 200 percent of poverty line. Although the Secretary of Health and Human Services cannot waive "any Federal law or requirement that is not within the authority of the Secretary" (p. 218), which is likely to include ERISA protections of employer-sponsored plans (thereby limiting the potential expansiveness of reforms), the potential expansiveness of this should not be underestimated. Further, any state operating under a waiver will receive fully 100 percent of the value of the federal affordability tax credits that would have otherwise gone to the state's residents.

[71] The federal transfer was initially set at 85 percent of the value of the tax credits that would have otherwise gone to the individuals purchasing health insurance through the exchanges. However, discretely incorporated into Senate Amendment 3276 (to amend the Senate's version of H.R. 3590) was a costly increase in the subsidy's to 95 percent of the value of the federal tax credit; this amendment also allows legal immigrants earning less than 133% FPL but not eligible for their state's Medicaid program to enroll into the Basic Health Plan (*Congressional Record*, 19 December 2009, p. S13495).

will be subsidized by the federal government. As such, the proportional share of total Medicaid expenditures financed by the states will continue to decline relative to the federal-share. How this dynamic will impact the incentives of states to control overall costs will remain to be seen.

Conclusion

While the Congressional Budget Office, think tanks and policy scholars would on occasions make a study of the formula for calculating the states' respective federal medical assistance percentages, the historical narrative told over the past four chapters sections suggests the futility of such exercises. Few in public office have seriously debated Medicaid's funding arrangement and the impact of the equalization formula on lessening state inequities. Despite a myriad of potential factors that could be considered in appropriating the hundreds of billions of federal dollars to the states and territories it would be safe to assume that most members of Congress and the administrations would admit, like Secretary Arthur Flemming did back in 1960, to a complete lack of any "dogmatic feeling relative to the exact nature of the formula."

Aside from a technical change in 1986 that accelerated the publication of the matching rates from a biennial to an annual basis and the temporary increases in the federal match as a consequence of general shortfalls in state and local revenues in 2003 and 2009-10, the FMAP has remained unaltered since 1958, with the fiscal relationships between the states and federal government still resembling what it was in 1965 when Medicaid was casually enacted as part of the Social Security Amendments of 1965. Instead of real reform to the FMAP or general funding arrangement for Medicaid, Congress has only been capable of stopgap responses to a pressing fiscal problem. In 1981, it was the nation's increasing federal deficit that pushed Congress to impose an ad hoc reduction in the federal share. In 2003 and 2009, it was the depressed

economy and the fiscal strain that compelled Congress to pass ad hoc increases in the federal share—like DSH payments in the early nineties and UPL payments later in that decade, this supplemental federal assistance has never been the result of any systematic reform of the FMAP formula.

By the mid-Nineties, Congress had finally accepted that the states' Medicaid commitments had finally become fiscally unsustainable. After decades of enrollment growth and increasing Medicaid costs the states' commitment to Medicaid as a share of their finite budgets has reached its natural limit. Each reform affecting Medicaid since the Republican's attempt to block grant Medicaid in 1995 has involved a reduction in the states' proportional share of Medicaid costs. Despite its near-success, the Republican's Medigrant reform attempt likely represented the last serious attempt to devolve to the states the inherent fiscal risks posed by Medicaid and attempt to cap federal contributions to the states.

The reform of Alaska's FMAP to reflect its higher cost of living and the recusal of New York's DSH payment-related liabilities in 1997 were admissions by Congress, however marginal, that the FMAP formula's reliance on per capita income inadequately reflected certain states' actual financial need. More significantly, and unlike the fiscal support provided for the Medicaid mandates passed during the 1980s, the more generous financing of the Children's Health Insurance Program was a bipartisan acknowledgment that states could no longer bare the full cost of any further expansion of Medicaid. And whereas in the past the states have always been expected to adjust their own budget priorities during recessions to meet the unanticipated costs of Medicaid, twice this decade—in 2003 and 2009—Congress passed emergency supplemental appropriations that recused the states of the countercyclical costs associated with Medicaid. The states' need for supplemental payments to meet the increased demands for Medicaid services, and the federal government's acquiescence to this need was evidence of the unsustainability of Medicaid's status quo funding arrangement.

Such increases to federal match reflected awareness by Congress that the states with their limited financial resources and revenue raising capabilities cannot sufficiently meet the increasing fiscal demands of Medicaid. That the massive expansion of Medicaid included in the health reform legislation of 2010 is to be financed almost entirely from the federal treasury demonstrates the futility of imposing a greater fiscal demand upon the states to meet the public objective of expanding access to health care.

Section III. A Quantitative Study of Medicaid Spending, 1980-2008

Introduction

The primary emphasis thus far has been an exploration of the historical development of Medicaid's cost sharing formula and its impact on Medicaid costs—in particular the cost of Medicaid to the federal government, and to a lesser extent the cost to the states. In Chapter 1, I provided a theoretical understanding of Medicaid's cost sharing structure. I argued that inefficiencies of the federal-state cost sharing arrangement obfuscate Medicaid's true costs and thereby contribute to a general tendency by the states to incessantly raise Medicaid expenditures. In Chapters 2 through 5, I offered a legislative history of Medicaid's financing policies and the primary political debates over the political development, or lack thereof, of Medicaid's intergovernmental cost sharing arrangement. This history demonstrates how federal efforts to fundamentally reform Medicaid's cost sharing arrangement and reign in federal expenditures have repeatedly failed. While there have been many obstructionists to reform, a persistent force of opposition have been the states that have been generally hesitant to accept any greater fiscal burden for their Medicaid commitments. Contrary to the consistent efforts of some members of Congress and Republican administrations to rebalance the shared responsibility between the states and federal governments for underwriting Medicaid, the federal government has seen both its absolute and proportional shares of Medicaid's fiscal liabilities steadily increase over the past. Further, to incentivize the continued and expanded participation of the states, the federal government has more recently responded to the states' heightened fiscal strains by increasing the federal matching rate, thereby exasperating the disincentives that states have to control their Medicaid budgets.

With only few exceptions, the empirics and narrative of the previous section emphasized the general inflation in Medicaid expenditures in the aggregate and the associated fiscal burden that these costs

have imposed on the federal government. The national narrative has not, yet, addressed the significant variation in Medicaid programs that persists across the states even despite the program's absolute growth at both the national and state levels. It is somewhat surprising given the great extent of state and federal commitments to this welfare program that there has been neither a race to the bottom in terms of the program's eligibility and benefits nor even an apparent regression toward the mean in its overall costs. This section transitions from historical empiricism to quantitative analyses that examine those state-level policies that contribute to Medicaid's high cost and the high level of variation in the states' Medicaid programs.

Chapter 6 is a quantitative study that examines various causal factors contributing to the stubborn state-level variation in Medicaid policies that determine the states' overall Medicaid expenditures. The chapter introduces an original dataset of three decades of state-level Medicaid data collected from data archives at the Center for Medicare and Medicaid Services. I use this data to construct proxies for Medicaid's costs to taxpayers, the poor's access to Medicaid services, and the quality of benefits provided to Medicaid recipients. These proxies are employed in several related multivariable time-series statistical models that examine how certain state-level factors related to economics, ideology, and interest groups influence the observed variation in Medicaid policymaking.

Chapter 7 looks at the cost of Medicaid from a different perspective. Using fiscal year 2008 data, I offer nuanced estimates of the cost of Medicaid to taxpayers, in both their capacity as Americans and as residents in particular states. The chapter quantifies both the direct taxpayer burden and the states' aggregate liability for the nation's Medicaid expenditures. By transforming the data to reflect the progressivity of federal taxation, the impact of Medicaid's funding formula, and the state's revenue sources, the chapter presents what is arguably a better approximation of Medicaid's true opportunity cost to taxpayers and states. While significant variation still exists in what each of the state governments demand of their residents in support of the state's welfare medicine program, the variable funding sources mitigate the

direct cost of the state's fiscal commitments, thereby increasing the perceived benefits of the program relative to its apparent costs.

Chapter 6.

Examining the Relationship of Benefits and Coverage on Medicaid's Costs

The iron triangle of health care financing is an apt metaphor used to illustrate the trade-offs inherent to health care financing. The iron triangle refers to the relationship between access, quality, and costs and is used to describe how any reform to one of the major components of health care delivery will necessarily affect one or both of the other components. The American health care system cannot simultaneously make improvements along all three vectors. For example, despite the efforts to innovate and enhance the delivery of health care at a lower cost, the reality is that any expansion in access or improvement in the quality of care is likely to come at a higher cost. Conversely, the only way to guarantee substantial savings is by reducing access to insurance and/or lowering the scope of coverage.

Constrained as it is by the iron triangle, Medicaid policymaking too reflects a zero-sum game. Further, with state balanced budget laws limiting the state governments' abilities to redistribute, the states must weigh the trade-offs in emphasizing the quality or access vectors of the iron triangle in favor of controlling costs. Any increase in Medicaid spending will generally need to be offset by a corresponding (proportional to the state's federal matching rate) increase in tax revenues or decrease in public spending for other services. Of course, states have alternative options for expansions: if a state does not want to impose such costs on the public but nevertheless desires to expand eligibility criteria for Medicaid, the state could decrease the number of optional Medicaid services provided or lower reimbursement rates paid to providers; conversely, a state could increase benefits or raise reimbursement rates but decrease eligibility. In each instance there are clear winners and losers among the providers, beneficiaries and taxpayers.

However, in the introductory chapter, I presented a simple game theoretic model to describe how the federal government uses the FMAP formula to incentivize states to pursue expansionary Medicaid policies by reducing the cost to the state taxpayer. By reducing a state's own fiscal liability for its policies, the federal match in effect lessens the ability of the cost vector of the iron triangle to constrain the state's policy decisions with respect to the other two vectors. Considerations of costs are not eliminated, however. With states still financing between 20 to 50 percent of Medicaid's net cost and Medicaid programs consuming ever-greater proportions of state budgets, state policymakers must still weigh the costs and benefits of sacrificing one or more vectors of the iron triangle in favor of the other(s).

This chapter presents three interrelated statistical models to help understand the different compromises, if any, that states policymakers select in setting their Medicaid eligibility and benefits criteria and the impact that such policy decisions have on a state's overall Medicaid spending. Consider the following figures that are not atypical of the general variation that is prevalent even among relatively comparable states. In North Dakota primacy care physician typically gets paid 135 percent of what Medicare reimburses, compared to about half that amount, 69 percent, in neighboring South Dakota (2012 data, statehealthfacts.org); in New York a parent in a household earning 150% of poverty is eligible for Medicaid insurance, whereas in Texas the household income of a parent can be no more than 12% of poverty (2010 data); in Pennsylvania, a 31.8% of the state's budget is appropriated for Medicaid services, compared to 16.2% in neighboring Delaware (fiscal 2011 data, National Association of State Budget Officers). Using two independent models I explore the relative influence of various social, political and economic factors on the two constitutive components of the states' Medicaid and CHIP programs—the state's eligibility criteria in relationship to the state's poor population (i.e. access) and the average spending for each recipient (i.e. quality). I then consider how variation in access and quality affects state variation in Medicaid spending per capita (i.e. costs).

The chapter proceeds as follows: I will next introduce the primary dependent variable, *costs*, and its two primary explanatory variables—*benefits* and *coverage*—that also serve as dependent variables in two associated models. Given these primary variables, I offer a series of hypotheses related to specific economic, partisan/ideological, interest group factors and the controls to explain the significant and persistent level of variation in *costs*, *benefits*, and *coverage*.[72] Before presenting the results of the three associated regressions I will define and defend the model. The final section considers the results and offers some possible extensions to the model for future investigation.

Primary Variables: *Costs, Benefits, and Coverage*

This chapter's multidimensional approach to studying Medicaid follows Colleen Grogan's (1994) examination of the determinants of a state's discretionary choices over its Medicaid policy. As Grogan articulated, "the practice of using the same global state determinants in several diverse state policy studies, such as interparty competition or state median income, obscures the reality that the factors affecting policy decisions vary according to the specific policies confronted" (1994: 590). She further argued that even within a specific policy area, particularly one as complex as Medicaid, the impact of certain factors might be

[72] Throughout this chapter, I use "inequity" and "variation" as synonyms. Variation itself is too neutral a term and diminishes the multidimensional costs of redistributive policies. The states' different Medicaid policies impose unequal costs and provide concentrated rewards on different subsets of the population. Although equity has strong normative and ethical connotations, "inequity" better captures the inherent trade-offs in sacrificing one or more vectors of the iron triangle in favor of the other(s). I do not impose a specific standard of fairness, but any variation in the eligibility criteria, reimbursement rates or taxpayer burdens among states programs can be construed as a potential form of inequity for some. For example, any increase in Medicaid spending will generally need to be offset by a corresponding (proportional to the state's federal matching rate) increase in tax revenues or decrease in public spending for other services. Thus, we must not consider just the inequity of the poor in terms of their lack of access, but also the relative inequity of the taxpayers underwriting Medicaid and the doctors and hospitals performing its services. Of course, states have other options for expansions: if a state does not want to impose such costs on the public but nevertheless desires to expand eligibility criteria for Medicaid, the state could decrease the number of optional Medicaid services provided and/or decrease its reimbursement rates paid to providers; conversely, a state could increase benefits and/or reimbursement rates but decrease eligibility.

variable depending on the dimension of the policy under consideration—for example, eligibility criteria versus spending on benefits per enrollee. Michael Bailey and Mark Rom (2004) have similarly demonstrated the importance of looking at different dimensions of a policy in their quantitative study on the variable impact of interstate competition across multiple measures of state redistributive programs, including Medicaid, AFDC and Supplemental Security Income-State (SSI-S) policy.

Grogan (1998) and Bailey and Rom's (2004) models rest on the assumption that certain political, economic, or social factors can contribute in different ways to different components of a state's means-tested policies. By ignoring the multidimensional aspect of welfare politics, the substantive significance of certain variables may be needlessly lost due to their statistical correlation with other variables in the model. For example, hospitals and other health care professionals have an economic incentive to seek an increase in reimbursement rates and they are likely to be unconcerned about the marginal increase in state spending that higher reimbursement rates may impose on the average state taxpayer. Conversely, some of those same providers may be indifferent, or even be actively opposed to enrollment expansions intended to improve access to Medicaid in their respective state if it meant that a doctor would be expected to accept more patients at relatively low Medicaid reimbursement rates. Yet either higher reimbursement rates or broader coverage will likely increase overall Medicaid spending, holding all else constant. Given the potential for desperate preferences among various stakeholders the relative influence of health care providers on Medicaid policy, for example, might be difficult to discern if the policy is not disaggregated into its constitutive components. Ignoring the different dynamics at work with respect to eligibility criteria and benefits may muddle the independent effect that certain variables, such as the strength of hospitals in the state, have on the distinctive policies associated with state Medicaid programs.

The dependent variables for the three interrelated, but distinct, models (with the former two variables serving as explanatory variables for the latter) are as follows:

I. ***Costs***: Total Expenditures per Capita

II. ***Benefits***: Medical Payments per Recipient

III. ***Coverage***: Number of Recipients as a Percent Poverty Population

Pairwise correlations between the three proxies support the supposition that different dynamics influence the three components of the health care iron triangle.[73] Although *cost* is positively correlated with *access* and *quality*, the proxies for *access* and *quality* exhibit no correlation with each other. The absence of a relationship between *access* and *quality* offers preliminary evidence that the Medicaid policymaking process varies across the state and across the specific dimension of Medicaid under consideration, with certain states favoring liberalizing eligibility criteria for basic services over delivering comprehensive services to only the poorest residents and vice versa in other states. As such, any empirical analysis exploring the causal impact of various independent variables on a state's aggregate spending on Medicaid should therefore first differentiate between the direct and indirect effects such variables may have on the different components of Medicaid policy.

Costs Dependent Variable

The *costs* variable is this study's primary dependent variable of interest and reflects annual state share of spending on Medicaid and CHIP per capita. I use the state's share of Medicaid expenditures because I am interested in the direct cost of the program to residents. I could have used total spending inclusive of the share reimbursed by the federal government and then controlled for the state's FMAP rate, but this alternative measure would understate the absolute variability in the state residents' liability for Medicaid.

[73] See **Table 6.2** below, following an introduction to each of the primary variables.

The expenditure data is derived for fiscal years 1980-2009 from the Medicaid Financial Management Reports provided by the Center for Medicare and Medicaid Services (CMS).[74] These public forms provide annual aggregate state–level summaries of state and federal spending by broad benefit categories as reported in Form CMS-2082 (formerly Form HCFA-2092), Form CMS-64 and, since 1997, Form CMS-21 (summarizing expenditures related to the implementation of the Children's Health Insurance Programs). A measure of total Medicaid/CHIP spending was calculated by summing the "Net Expenditures Reported" lines from the state share "Medical Assistance Payment" and "Administration" files. For the fiscal years after the 1997 implementation of State Children Health Insurance Program, I sum the "C-Total Net" and the SCHIP-related "Net Expenditures" line. I divide total Medicaid/CHIP spending by the state's resident population, using the Census Bureau's annual midyear population estimates.

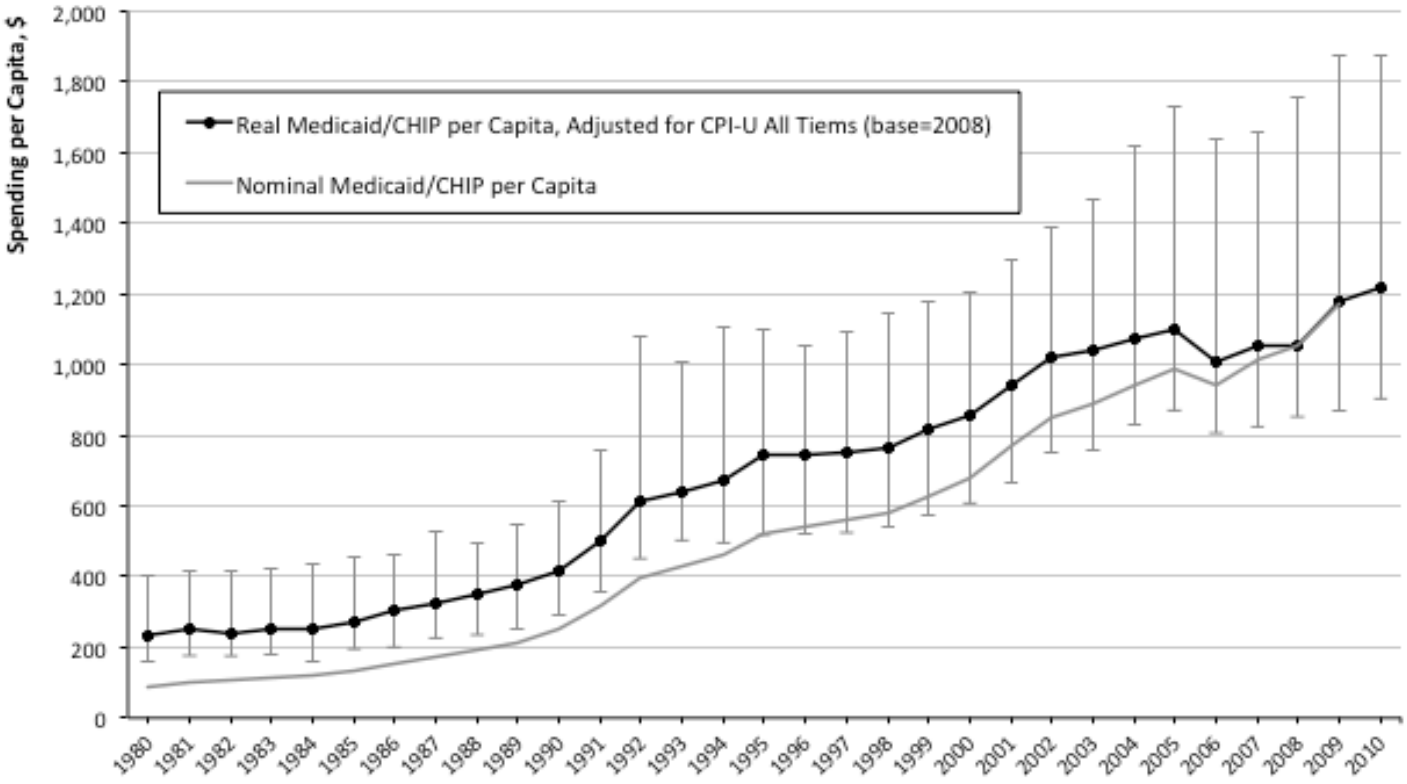
Figure 6.1 charts the historical trend in the median spending on Medicaid per capita among the states between 1980 and 2009 (adjusted for inflation using the Bureau of Labor Statistics' Consumer Price Index (CPI-U All Items) to reflect comparable real value of the dollar (base=2008)), as well as the range reflecting the 10th and 90th percentiles. Even after adjusting for inflation, the median level of real spending per capita has increased over five-fold during the study's period, from $230 in 1980 to $1,220 in 2009. The lighter solid line represents the state median for the unadjusted *Costs* data.

In fiscal year 2009, total federal-state expenditures for the Medicaid program was $384.3 billion with expenditures under the CHIP program adding $10.7 billion. Comparatively, federal direct spending on Medicare (i.e. not including the premiums paid for Part B and Part D and state contributions for the dual eligible) was $429.3 billion in 2009. By 2015, total spending on Medicaid and CHIP, including the estimated impact of the Affordable Care Act that will expand coverage to approximately 16 million more

[74] Expenditure data from annual Financial Management Reports, summarizing data from the CMS-2082 and CMS-64. Fiscal year 1997 through 2009 are available online from Center for Medicare and Medicaid Services; reports from 1980 through 1996 were acquired by special request to CMS.

people, is projected eclipse the total direct spending on Medicare: with Medicaid expenditures reaching $649 billion compared to $635 billion for Medicare (Social Security Administration 2011; Federal Register 78(33): 9233-49). Unlike Medicare that has approximately half of its expenditures financed by payroll taxes and interest earnings, Medicaid is financed almost entirely by state and federal general revenues.

Figure 6.1. Total real Medicaid/CHIP spending per capita (in 2008 dollars), Median and 10th/90th Percentile, by State, FY 1980-2010



Note: Medicaid/CHIP data adjusted by averaging CPI-U All Items for each Fiscal Year (e.g. 1980=average of October 1979 through September 1980), CPI multiplier uses base 2008

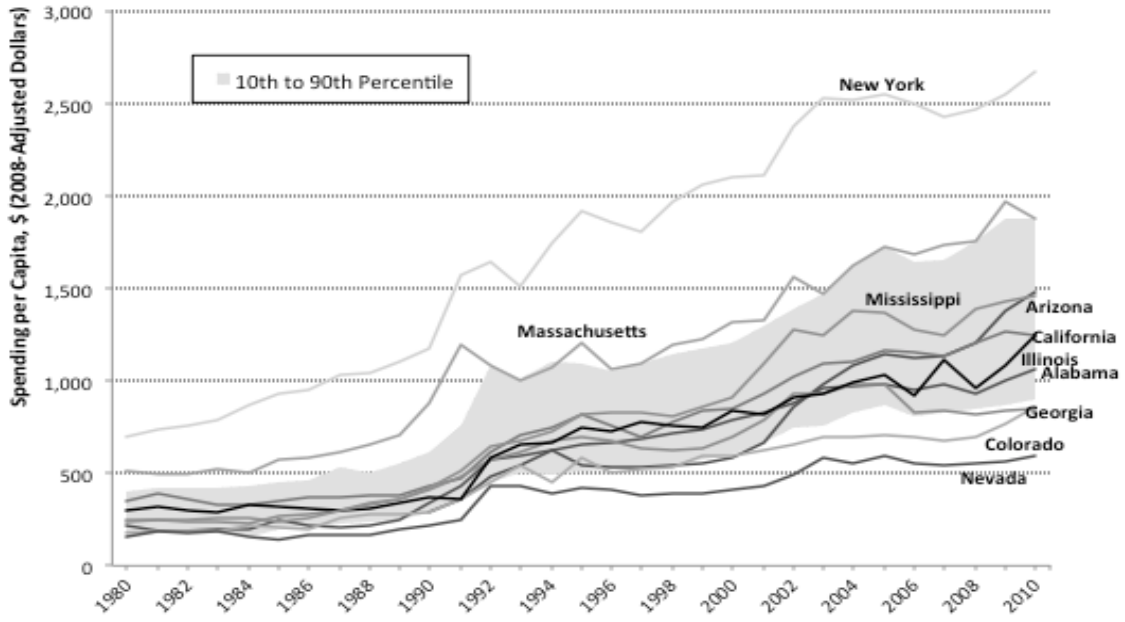
Sources: expenditure data from Center for Medicare and Medicaid Services (Annual FMR Data Reports); state population data from U.S. Census Bureau

Contrary to the hypothesis that federalism tends to have a moderating affect on social policies, the amount of variation between the states has remained persistent (even after controlling for inflation). With

the real value of the states' spending commitments increasing significantly across all states over the three decades there has been no indication of a "race to the bottom" among the states in their commitments to Medicaid. Every state has drastically increased their fiscal commitment to Medicaid/CHIP, with the 10th and 90th percentile of states' per capita spending on Medicaid increasing from approximately $160 and $400 in 1980 to $900 and $1,900 in 2009, respectively.

Figure 6.2 shows adjusted (for 2008 dollars) Medicaid spending per capita in ten representative states. The shaded area represents the 10th and 90th percentile. All figures represent real dollars adjusted for the impact of general inflation (base=2008). The figure demonstrates how the rate of growth in spending varies significantly across the states. For example, for the ten year period between 1992 and 2001, real spending on Medicaid in Nevada remained flat, while real spending in New York increased by a third.

Figure 6.2. Total real Medicaid/CHIP spending per capita (adjusted to 2008 dollars), 10 individual states and 10th-90th percentile range, FY 1980-2010



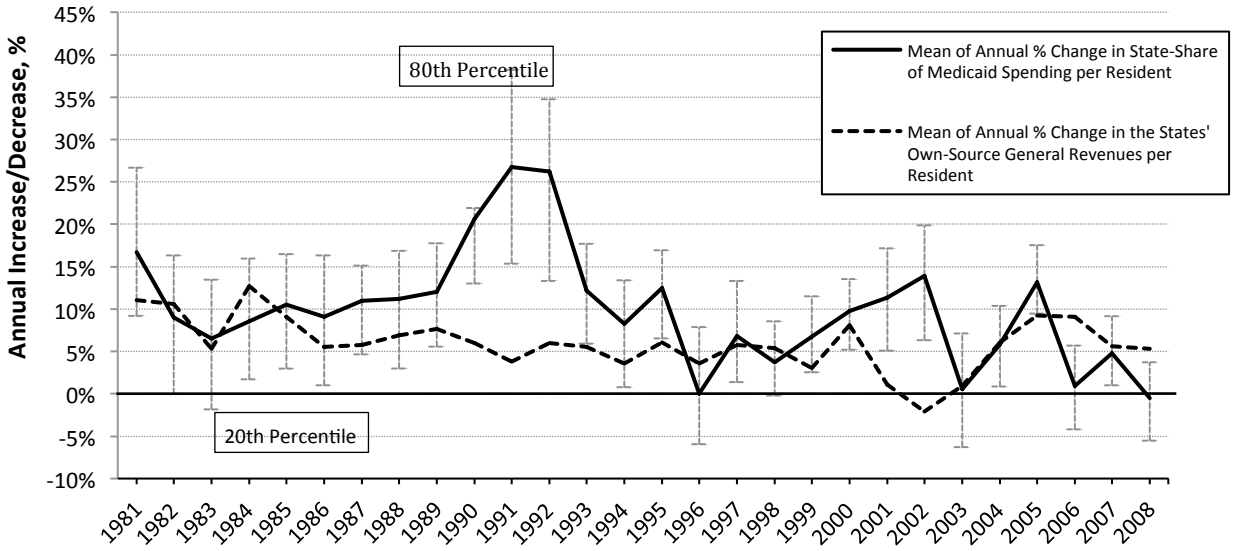
Note: Medicaid/CHIP data adjusted by averaging CPI-U All Items for each Fiscal Year (e.g. 1980=average of October 1979 through September 1980), CPI-U All Items multiplier uses base 2008

Sources: expenditure data from Center for Medicare and Medicaid Services (Annual FMR Data Reports); state population data from U.S. Census Bureau

It is further worth noting that the relative ranking of states with respect to per capita spending on Medicaid has changed over the years. While New York and D.C. have consistently had some of the costliest Medicaid programs in the nation and Nevada remained one of the cheapest, most states have seen their relative costs fluctuate. Of the 10 states falling outside the 10th and 90th percentiles in 1980, only four remained among the relative outliers in 2009; and among all states the median state has seen its ranking move 23 positions over the 30 years. Similar temporal and intra-temporal variations are noted for *coverage* and *benefits*.

Figure 6.3 presents data on the annual inflation of Medicaid spending and the 10th and 90th percentile changes; the dotted line represents the mean rate of change in the states' total general revenues. It is evident that the rate of growth in Medicaid expenditures fluctuates considerably both across time and between states. Between 1980 and 2008 the rate of inflation in Medicaid spending has averaged 9.7%, with an average standard deviation of 11.5% inflation over the past decade. By controlling for the previous year's *cost*, the models emphasize the marginal changes.

Figure 6.3 Annual Percent Change in the 50 states' (excludes DC) (a) own-source general revenues per resident and (b) state-share of Medicaid spending per resident



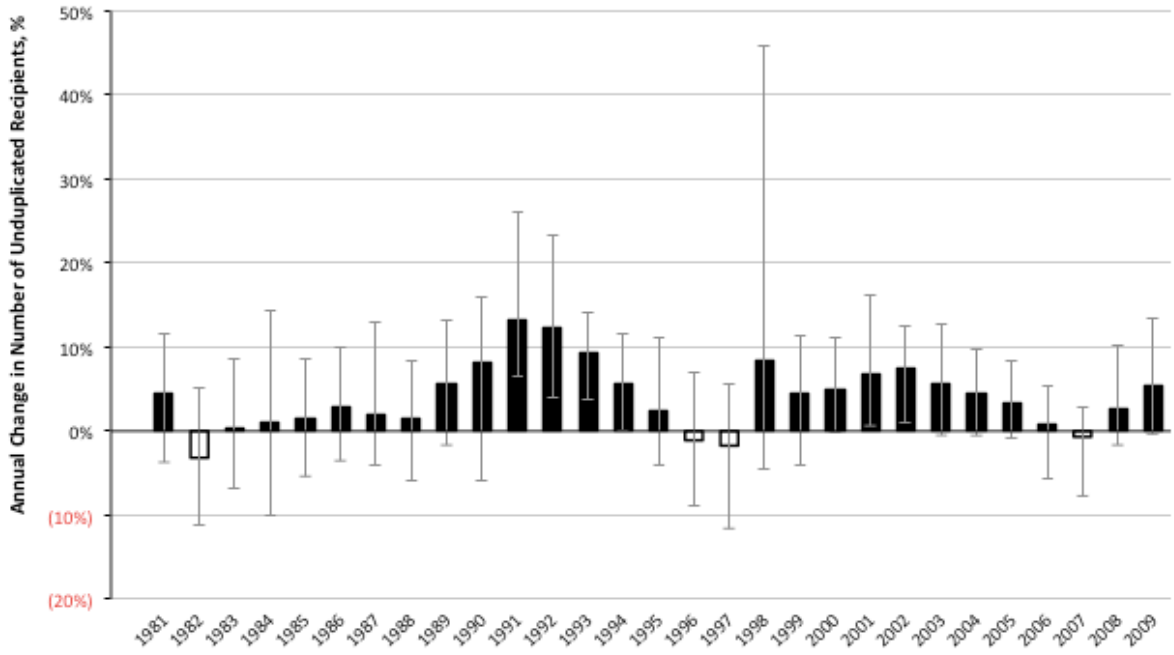
Before proceeding to the next variable of interest, a significant qualifier about the *costs* variable should be emphasized. The states have ways to inflate their Medicaid budget that are not directly associated with their Medicaid expenditures per se but are not reflected in this proxy. For example, as discussed in Chapter 5, after distributing DSH or UPL payments to hospitals and collecting federal reimbursements according to its FMAP rate, a state can impose specific provider taxes on hospitals to recoup a portion of their own state-level expenditures as well as some of the federal disbursements. Although the DSH/UPL payments appear in the Medicaid budgets used in the constructing the *costs* variable, any potentially offsetting provider taxes do not appear in the Medicaid budget. For example, assume a state legislature wants to respond to voter pressure to reduce state deficits by cutting $5 millions from budget. The state could reduce reimbursements rates to hospitals. Or, the state could provide $20 million in DSH payments. Collect $10 million from the federal government and then institute $15 million in new taxes. It may be counterintuitive, but effectively the combination of DSH payments and provider taxes allowed both the hospitals and state to each net $5 million in new revenues, paid for by federal taxpayers. Such practices were common in the early 1990s and anecdotal evidence suggests that states still employ provider taxes to leverage federal revenues, thereby raising Medicaid expenditures without actually raising the actual state-level taxpayer burden of Medicaid that the *costs* variable is intended to represent. All of the *costs* models understate this tendency.

***Coverage* Variable:**

After a period of stagnation in the number of Americans enrolled in Medicaid in the 1970s followed by a period of actual retrenchment in the early 1980s the number of Medicaid recipients increased rapidly over the subsequent decades, nearly tripling from approximately 25 million in 1980 to nearly 70 million three decades later. **Figure 6.4** presents the annual change in the absolute number of Medicaid recipients

(unduplicated count), by state. Even during much of the Eighties when Medicaid was experiencing below average rates of growth in its enrollment, many states still experienced increases in the number recipients that approached 10 percent. The significant bump in enrollments in 1998 corresponds with the implementation of S-CHIP.

Figure 6.4. Median Annual Change in Number of Annual Unduplicated Recipients, by State, FY1981-2009



Notes: In 1998, Medicaid beneficiaries were redefined to include enrollees on behalf of whom a capitation payment is paid; CHIP data not included for FY05, FY07 and FY08 (Unavailable as of 08. 29.2011)
Sources: Unduplicated recipient account from MSIS: 1980-1990: data request from Center for Medicare and Medicaid Services (CMS) 1991-1998: Annual Statistical Supplement; 1999-2009: MSIS State Summary Datamart at msis.cms.hhs.gov

Absolute enrollment numbers, however, do not control for either population growth or the population's relative need for Medicaid over time. Therefore, for the proxy of the poor's access to Medicaid insurance, I construct the variable *coverage* by taking the total number of Medicaid recipients in a state and dividing it by the number of residents who are living under the federal poverty line. With respect to the Medicaid populations, the state-level recipient counts for the years 1980-2009 were taken from the *Social Security Bulletin – Annual Statistical Supplement* (for 1980-1998) and the Medicaid Statistical Information

System (for 1999-2009). These statistics represent the total annual number of unduplicated recipients in Medicaid or CHIP. This includes anyone who has had Medicaid services provided at any point in the year (and includes those enrolled in Medicaid managed care plans who may or may not have received any actual health care services).[75]

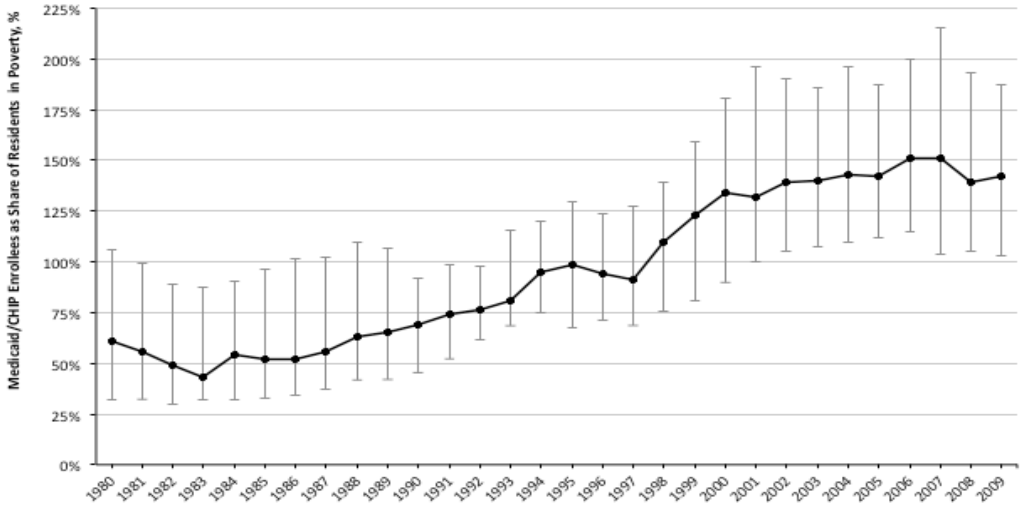
The number of poor, used in the denominator of the *access* variable, reflects the number of residents in a state living with household income less than 100 percent of the federal poverty line, as estimated by the US Census Bureau and found in their "Detailed Poverty Tables." For example, if a state has 1 million residents living below the poverty line and 1.4 million Medicaid recipients, the *coverage* proxy for the state would be 140% of the poor. Scaling the number of recipients to the poverty rates allows the model to compare states of different sizes. It also implicitly emphasizes how over time Medicaid has become less exclusively a poor person's program. Although it may be beneficial to adjust the measure of "poor" to reflect variation in the cost of living across the states, as Medicaid's categorical eligibility criteria and FMAP formula are tied to federal poverty levels, the federal measure is sufficient. (I do control for income in the regression model, however.)

Figure 6.5 charts the historical trend in the median and $10^{th}/90^{th}$ percentiles of the states' coverage over thirty years. Nationally the number of poor who have gained access to Medicaid has increase from 60 percent of those below the poverty line to about 140 percent of those in poverty. By 140 percent of the poverty (or 140 percent of the 'poor' in the state) I do not mean the eligibility criteria, but the absolute number of recipients. Throughout the Eighties (and for much of the decade before), national enrollment for

[75] It is worth nothing that there is significant turnover in Medicaid enrollees as household income and therefore eligibility for Medicaid fluctuates during the year. This will lead to some incongruence between the poverty figure that reflects net *annual* household income and the Medicaid enrollment figure. A more appropriate measure of Medicaid caseload would arguably be the states' average monthly enrollments, also called full-year equivalents. Since 1997 the Kaiser Commission on Medicaid and the Uninsured have conducted bi-annual surveys that offers point-in-time estimates (for June and December) of the number individuals enrolled in Medicaid.

Medicaid stubbornly held around 22 million annual recipients with median *coverage* falling below 50 percent of the states' poor in 1983 (the last year of the OBRA '81 cuts to federal Medicaid spending). But after declining in the first half of the decade, the share of the poor with access to Medicaid steadily increased between 1986 and 2000 with a temporary (and largely unintended) decline following national welfare reform of 1996 and improved economy. It is worth emphasizing that despite the series of mandates passed during the 1980s that significantly liberalized and federalized Medicaid's eligibility criteria, there remained nearly as much variation among the fifty states in 2009 as there was in 1980, with several states providing Medicaid/CHIP to nearly 200 percent of the number of residents who were "poor", while other states provide proportionally half that level of coverage. For example, non-working parents in Pennsylvania qualify for Medicaid through its CHIP program if the family's income is below twice the federal poverty level ($44,100 for a family of four in 2008). In Louisiana, however, non-working parents qualify only if their incomes are below the state's TANF eligibility criteria equivalent to 11 percent of the poverty level ($2,426 for a family of four).

Figure 6.5. *Coverage* variable – Medicaid/CHIP Recipients as percent of state residents in poverty, median and $10^{th}/90^{th}$ percentiles, by state, FY 1980-2010



Note: In 1998, Medicaid beneficiaries were redefined to include enrollees on behalf of whom a capitation payment is paid; CHIP data not included for FY05, FY07 and FY08 (Unavailable as of 08. 29.2011)
Source: HCFA/CMS MSIS Unduplicated Recipient Count (Data Request: 1980-1998, msis.cms.hhs.gov: 1999-2009)

While using the number of Medicaid recipients has the advantage of measuring actual participation in the states health care systems, this number underestimates the ability of eligible state residents to receive Medicaid services because it does not include residents who are neither enrolled in a managed care plan nor who make no use of any health services in a year. Significantly, Medicaid coverage can be applied retroactively—up to three months of retroactive coverage can be provided to eligible recipients prior to application who required coverage and had alternative source of medical insurance. Not only does this create a severe adverse selection it effectively means that an individual or family has little incentive to apply for Medicaid without an *a priori* need for care. From an insurance perspective this is counterintuitive.[76] A preferable proxy for the poor's access to Medicaid could arguably be an estimate of a state's potential enrollment based on total eligible population. Significantly, a 2008 study by *National Institute for Health Care Management Foundation* estimated that approximately a quarter of the 47 million then uninsured in 2006 were eligible for Medicaid, including an estimated 6.1 million children, nearly two of every three uninsured children (NIHCMF, 2008).[77] However, this data is inconsistent and less reliable for this study's extended

[76] The *benefits* variable, introduced next, all suffers similar defects, with Medicaid's adverse selection problem leading to the overestimation of the true cost of providing Medicaid insurance to Americans because it excludes nonusers who are an essential part of any insurance pool.

[77] The enrollment of these currently eligible Medicaid recipients is one of the concerns that many states share with respect to state-level fiscal burden associated with the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) is over eligible-but-not-yet-enrolled individuals. The Act stipulates that newly eligible Medicaid recipients will be eligible for 100 percent federal cost sharing (drawing down to 90 percent by 2019), but those whom are eligible for Medicaid under state criteria prior to implementation of the Act (regardless of whether or not they are enrolled) will have their costs subsidized according to the standard FMAP cost sharing arrangement. The Act's included mandate that individual's hold insurance coverage will likely lead to a significant rise in coverage rates among these previously eligible recipients.

time period. The *coverage* variable should be interpreted as a minimal estimate of the poor's access to Medicaid.[78]

Benefits Variable:

The *benefits* variable is intended to be a proxy of the comprehensiveness of the Medicaid coverage provided by a state. *Benefits* is estimated by taking total federal and state expenditures on Medicaid (as described above in relationship to *Costs*) and subtracting the amounts spent on administration and then dividing the balance—reflecting all provider payments and/or capitated managed care payments—by the total number of unduplicated recipients. It is arguable whether or not disproportionate share hospital payments should be excluded from a measure intended to indicate the generosity of Medicaid benefits. Where they are not used by a state to leverage federal dollars as a supplement to the state's general revenues such payments are intended to go, in part, to subsidizing the uncompensated care provided to hospitals treating non-Medicaid recipients; therefore, including DSH payment could inflate the level of spending that went specifically to actual Medicaid recipients. I do not make any adjustment, but given this feature of DSH payments and the potential fiscal abuses associated with DSH payments, particularly when they were are at their peak, I argue it is prudent to at least include them as a control in the models.[79]

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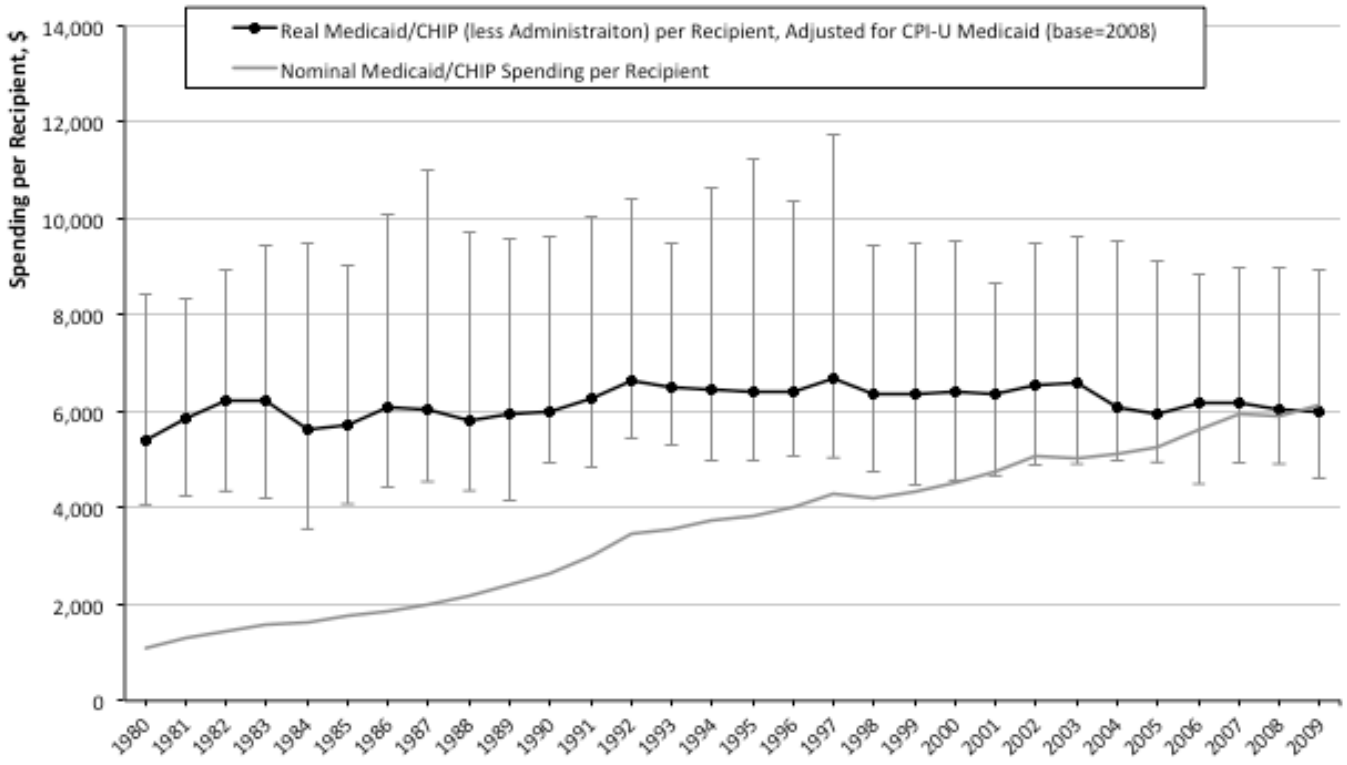
[78] Future research could explore whether or not states that have Medicaid managed care programs that provide a third party administrator ("TPA") a fixed amount per enrollee exhibit a higher level of penetration among their eligible populations, presumably because the TPA has an incentive to increase the number of recipients and reduce their per-recipient costs.

[79] Similar arguments can be made with respect to Upper Payment Limits, that I do include in the *Benefits* variable. Two reasons for this bias treatment are: (1) before 2009, the MFR data reports did not differentiate UPLs and so the data is simply unavailable; (2) whereas DSH payments subsidize the costs of uncompensated care provided to Medicaid and non-Medicaid recipients and so are not explicitly "Medicaid" benefits, UPL payments are *intended* only to increase the effective reimbursement provided for Medicaid recipients and so are more appropriately seen as Medicaid reimbursements (see Chapter 5 for discussion on DSH payments and UPLs)

Figure 6.6 charts the historical trend in the median spending on Medicaid vendor payments per recipient among the states between 1980 and 2009, adjusted for medical inflation using the Bureau of Labor Statistics' Consumer Price Index (CPI-U All Items) to reflect comparable real value of the dollar (base=2008), as well the range reflecting the 10th and 90th percentiles. Adjusted for medical inflation the spending has remained remarkably stable over the past thirty years. However, as in the cases of *Costs* and *Coverage* there has been no lessening of the variation among the states over time. (The lighter solid line in the figure represents the 50-state median for the unadjusted *Benefits* data.)

Figure 6.6 *Benefits* variable – Median real Medicaid/CHIP spending (less administration/DSH) per recipient, adjusted for CPI-U Medical care, median and 10th/90th percentiles, by state, FY 1980-2010



Note: In 1998, Medicaid beneficiaries were redefined to include enrollees on behalf of whom a capitation payment is paid. The large increase in 1997 is primarily the result of this change of definition.

Sources: expenditure and recipient (annual unduplicated recipient count) data from Center for Medicare and Medicaid Services (Annual FMR Data Reports and MSIS reports, respectively); CPI-U Medical Care from Bureau of Labor Statistics

With respect to the comprehensiveness of Medicaid coverage, all states must cover fourteen categories of basic services (as set forth in 42 U.S.C. 1396d(a)(1)-(5)[80]), but can apply to the CMS for waivers (Section 1115, Section 1915(b) or Section 1915(c) waivers) to avoid specific federal requirements related to the provision of certain services. States may also elect to include any among 34 optional services (as set forth in see. 42 U.S.C. 1396d(7)-(16)[81]).

Federal mandates (those associated with both eligibility and benefit criteria) create a confounding variable, or third variable, problem to our models. A confounding variable is an exogenous variable that a researcher fails to control for and yet is empirically related to both the other independent variables and the dependent variables in a model. The confounding variable problem associated with the federal mandates will make it difficult to disentangle the relationships and therefore the proper correlation of state factors that the states have control over and overall *benefits* (or *coverage* or *costs*). If a state's Medicaid benefits are defined exogenous to state specific factors any correlation exhibited between the independent variables and *benefits* could be happenstance and causality could not be discerned. To correct for this potential problem, Thad Kousseer (2002) disaggregated Medicaid funding into optional and mandatory coverage costs for the period 1979 through 1993. In his quantitative study he looks at the political and economic effects on

[80] Mandatory Medicaid services include: inpatient and outpatient hospital care; physician's service; nurse midwife service; pediatric and family nurse practitioner services; federally qualified health center ("FQHC"); laboratories and x-ray services; rural health clinic services; prenatal care; family planning services; nursing facility services for persons over age 21; home health care services for persons over 21 who are eligible for nursing facility services (includes medical supplies and equipment); early and periodic screening, diagnosis, and treatment for persons under age 21 ("EPSDT"); vaccines for children; transportation.

[81] Optional Medicaid services include: podiatrists' services; optometrists' services and eyeglasses; chiropractic services; private duty nurses; clinic services; dental services; physical therapy; occupational therapy; speech, hearing and language therapy; prescribed drugs; dentures prosthetic devices; preventive, diagnostic and screening services; rehabilitative services; services for persons age 65 or older in mental institutions; intermediate care facility services, including for persons with MR/DD and related conditions; inpatient psychiatric services for persons under age 22; Christian Science schools; nursing facility services for persons under age 21; emergency hospital services; personal care services; hospice care; case management services; respiratory care services; home and community-based services for individuals with disabilities and chronic medical conditions; Program for All-Inclusive Care for the Elderly ("PACE")

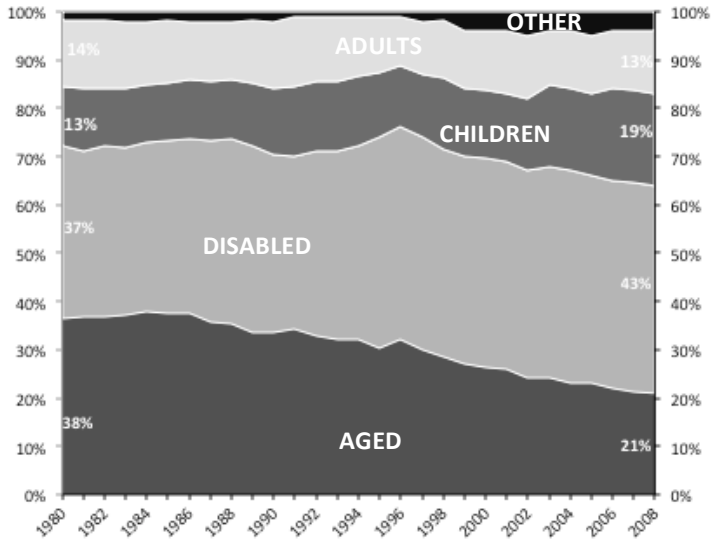
discretionary Medicaid expenditures and finds partisan effects where others have not. Unfortunately, he only looks at the period from 1980-1993 and the present study seeks to examine a longer time period. Kousser reasoned that policies and administrative rulings that have transpired since 1993 have made in more difficult to discern discretionary spending. Although the increasing level of discretion granted to the states during the Clinton and Bush administrations makes Kousser's results around the determinants of state-level policymaking all the more consequential, they also may lessen the need to isolate the optional spending from the mandatory spending totals. A study by the Kaiser Family Foundation (2005) on Medicaid expenditures and enrollment data (not including CHIP data) found that 60 percent of all Medicaid expenditures went toward "optional" services in 2001,[82] with 86% of all optional expenditures going toward paying for services provided to the elderly and disabled. Additionally, although certain services are mandated, the states still have considerable latitude in setting reimbursement rates and thus excluding spending on mandated services would remove this important source of variation from the study. From the perspective of a state-level analysis, the flexibility that states having for deciding upon the optional benefits provided and, more generally, the reimbursement paid mitigate the influence of potentially confounding nature of federal mandates on *benefits*.

Finally, with respect to *benefits*, it is important to recognize that a state's eligibility criteria and demographic mix will significantly affect the average cost of services provided to a Medicaid recipient in that state. In 2008 a child cost an average of $2,171 to be insured with Medicaid, compared to $2,646 for a

[82] Despite the number of Medicaid services that are technically optional, in most instances the purported flexibility is more superficial than real. For example, while prescription drug coverage is an optional benefit for all beneficiary groups other than children (for whom prescription drugs are required under EPSDT requirements), every state includes prescription drug coverage in their Medicaid package. This 'optional' benefit cost the states $24.2 billion, or 7 percent of total Medicaid/CHIP expenditures, in 2009. Similarly, intermediate care facilities for people with mental retardations ("ICF-MR"; see Section 1905(d) of Social Security Act) are an optional benefit that every state now includes. In 2009, $19 billion, about 5 percent of total vendor payments, was spent on providing care for Medicaid recipients in either mental health facilities or ICF-MR. While the demand for such services varies vastly across the states and the states' commitments to this subpopulation may vary, every state had at least one ICF-MR facility according to the CMS.

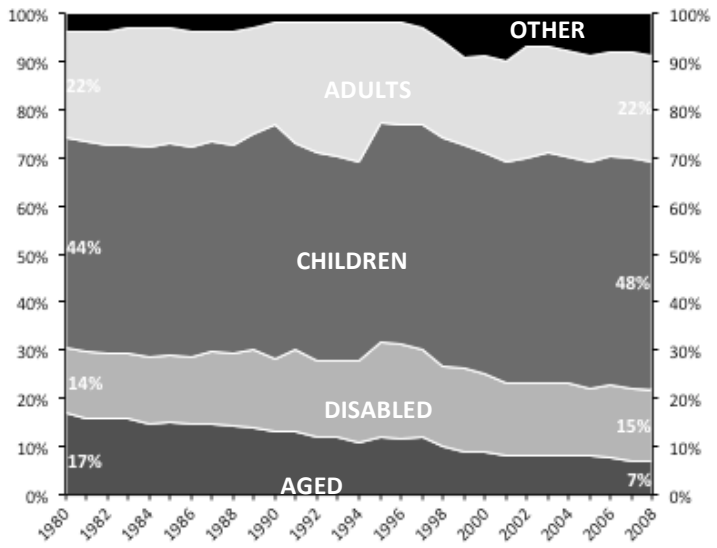
nondisabled adult, and $12,950 and $14,865 for the elderly and disabled, respectively. In Florida, for example, the annual cost of providing nursing home care to a single Medicaid recipient was approximately $65,000 in 2008; comparatively, the same amount of funding could provide a full year of CHIP coverage to almost 40 Floridian children in 2008.[83] **Figure 6.7a** and **Figure 6.7b** present a national summary of Medicaid's enrollment mix and spending between 1980 and 2009: the aged and disabled have always commanded a large share of total costs relative to their population. With costs so skewed, a state with expansive coverage for children and non-disabled adults may be classified as being less generous *benefits* than a state with comparatively restrictive eligibility but a proportionally higher number of aged or disabled Medicaid recipients.

Figure 6.7a. Share of total Medicaid payments by enrollment group, averaged across all states, FY1980-2008



[83] Throughout fiscal year 2008, Florida's CHIP program insured approximately 230,000 children a month (for an annual count of 350,000) at a total cost of $390 million (statehealthfacts.org). Comparatively, the average per diem Medicaid reimbursement rate for a day of nursing home care was $177.06 in 2008 (Florida Agency for Health Care Administration). And Florida was not particularly egregious in its high costs of nursing homes: a 2010 survey of state long term care ranked the affordability of private-pay long term care in Florida just above the median (Reinhard et al. 2011). Some states, such as New York and Connecticut, have annual nursing home costs that exceed $100,000 per long-term care resident on Medicaid.

Figure 6.7b. Share of Recipients by Enrollment Group, averaged across all state, FY1980-2008



Source: recipient (annual unduplicated recipient count) data from Center for Medicare and Medicaid Services (MSIS reports)

Correlation between *Cost*, *Coverage* and *Benefits*

Table 6.1 displays the simple pair-wise correlations between the above variables, averaged across the 30 years. As expected, both *coverage* and *benefits* are positively correlated with *costs*: the broader the coverage or more generous the reimbursement rates and/or services the more likely it is the state's overall program will also cost more. In contrast, the correlation between *benefits* and *coverage* is low—often negative or near zero. Over the past three decades the precise relationships between *costs*, *coverage,* and *benefits* has fluctuated.

Table 6.1. Pairwise Correlation Between Dependent Variables, Averaged Across States, by Period

Fiscal Years	1980-1989	1990-1999	2000-2009	1980-2009	Max (*Year*)	Min (*Year*)
cost* : *coverage	0.61	0.33	0.39	0.44	0.75 (*1981*)	0.17 (*1994*)
cost* : *benefits	0.50	0.60	0.53	0.55	0.71 (*1991*)	0.30 (*1980*)
benefits* : *coverage	0.12	0.02	0.03	0.06	0.25 (*1990)*	-0.27 (*1997*)

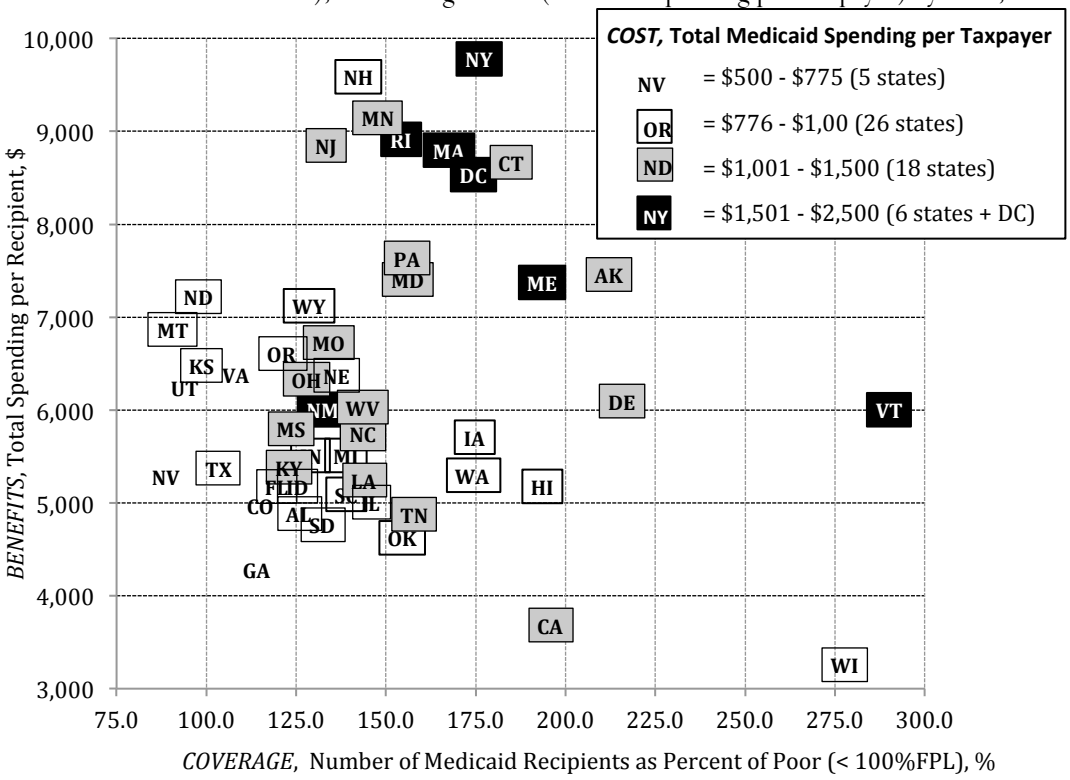
Note: *cost*: Total Medicaid/CHIP spending per Capita;
benefits: Total Medicaid/CHIP Spending (less Administration) per Unduplicated Recipient;
coverage: Unduplicated Recipient as % of Residents in Poverty
I also considered the pairwise correlation of the 50-state *ranking* of the states with respect to the three dependent variables. The results were comparable, suggesting that the correlation results were not driven by certain states having extreme values for the variables.

Source: Author's dataset

In the early 1980s the correlation between *costs* and *coverage* was marginally greater than the correlation between *costs* and *benefits:* 0.61 compared to 0.50. Through the 1990s the correlation between *costs* and *coverage* decreased significantly relative to the previous decade, suggesting that a state's eligibility criteria and therefore its total enrollments became less of a contributing factor to the states' overall Medicaid expenditures. A potential cause for temporary spike in the *benefits – costs* correlation in the early Nineties was the abuse of DSH payments that inflated aggregate costs and Medicaid payments per recipient without any concurrent increase in state enrollments. This also would have lessened the positive relationship between *coverage* and *costs* typically demonstrated. The declining correlation between *cost* and *coverage* is also consistent with the fact that most of the new enrollees insured through the Medicaid mandates of the late 1980s and the CHIP expansion of late 1990s and 2000s were children who are significantly less expensive to provide health care to than the old or disabled. Given the lower cost of providing Medicaid insurance to the newly enrolled children, and in some states, their parents and other healthy adults, the precise demographics and health status of a state's Medicaid population would become at least as important for determining a state's total expenditures as the absolute size of the population. Thus, states that can offer coverage more efficiently may be more willing to liberally expand coverage to additional children. Additionally, the repeal of the Boren Amendment in 1997 afforded the states greater flexibility determining reimbursement rates and therefore offset the costs of new enrollees by reducing payments if a state saw that to be prudent. The result would be that per capita costs could remain relatively low despite a state raising its eligibility standards.

The comparatively low correlation between *benefits* and *coverage* offers preliminary evidence that at least most states in designing their Medicaid programs make trade-offs between establishing high eligibility criteria on the one hand and offering a generous beneficiary package (and/or including high reimbursement rates) on the other. A state may choose, like California or Tennessee, to spread available resources thin, with broad eligibility and low reimbursement rates, or it may, like Arizona before the implementation of Prop 204 expansions in early 2000s, provide comparatively generous reimbursement for the care of an extremely low-income population. Fewer can afford, either politically or financially, like New York or Connecticut for example, to offer both generous coverage and comprehensive and favorably reimbursed benefits. **Figure 6.8** plots the *coverage* and *benefits* values of each state for fiscal year 2008 as the X- and Y-coordinates, with the states' general *costs* value indicated by the symbol identifying each states' point of intersection. The figure supports the correlations presented in **Table 6.1**. Overall, the absence of a positive correlation between the *benefits* and *coverage* variables suggest that different causal factors—as Grogan (1994) and Bailey and Rom (2004) similarly argued—are at work in determining each of the components of a state Medicaid program. Although rudimentary, this diagnostic provides a basis to assume that what primary factors contribute to variation in one of the above measures may not have the same effect for another. It is necessary to look at Medicaid policymaking from a multidimensional perspective.

Figure 6.8. Trade-off between *benefits* (Medicaid Spending per Recipient) and *coverage* (Medicaid Recipients as Percent of Residents above 100% FPL), controlling for *cost* (Medicaid Spending per Taxpayer) by State, FY 2008



Explanatory Variables

This section introduces the primary explanatory variables and demographic and economic controls that influence the states' variation in *coverage*, *benefits*, and *costs*. The explanatory variables are grouped into three loose categories: macroeconomic conditions, partisan or ideological, and interest groups.

I posit that *coverage* is determined largely by a state's political ideology and macroeconomic condition, controlling for state demographics; *benefits* are greatly influenced by interest group strength, controlling for local cost of health care; and, aggregate *costs* in addition to being determined by the state's *benefits* and *coverage* policies are directly affected by the macroeconomic conditions within the state and changes in state partisanship.

ECONOMIC Explanatory Variables:

Not all states have the same level of economic activity and, thus, comparable tax bases from which they can raise revenues to finance public programs. A poor state has an inherently smaller tax base than a rich state, and so the former would need to impose a higher tax rate on its residents if it sought to raise the same amount of money compared to the latter. The more likely outcome would be the poor state to provide fewer services than the rich state. To entice poorer states' to increase their financial participation in Medicaid while at the same time maintaining relative parity in the states' taxpayer burden across the nation, the federal government subsidizes the states' Medicaid costs with variable matching funds defined by the *Federal Medical Assistance Percentages* (FMAP). A state's FMAP rate is inversely related to the state's per capita income relative to the national average. If the FMAP was successful at redistributing federal revenues across the states there would be no significant relationship between total Medicaid spending per capita and either a state's per capita income or its associated FMAP rate.

However, the FMAP is an imperfect funding mechanism. Regardless of the intent of the FMAP to stimulate spending by more generously subsidizing poor states relative to rich states, it has proven to be insufficient at raising all states to comparable levels of total spending. With respect to the *costs* model I include a state's per capita income as an explanatory variable and expect a positive relationship between *per capita income* and *costs*. Alternatively, I could use a state's FMAP rate, but the endogeneity of the former to the latter make it inappropriate to include both metrics in a model. While substituting a state's FMAP rate for its per capita income does not substantively affect the coefficient of any of the other variables, I prefer per capita income to FMAP because the FMAP rates are limited to a statutory minimum of 50% and statutory maximum of 83%. However, I do include a dummy to indicate whether or not a state is affected by the 50% minimum.

I expect the state's *poverty rate* to be negatively correlated with *coverage*. Given that Medicaid is a means-tested program this relationship may be counterintuitive; and, indeed, the relationship is, in part, a result of the construction of the dependent variable. If two states had the same eligibility standard tied to, for example, 100% of the FPL, the state with greater poverty would have more residents falling into the eligibility category. However, because the *coverage* variable controls for the state's poverty rate (by using the number of residents living under the poverty line in the denominator) and reflects the share of a state's poor with Medicaid and not the share of the state's total population with Medicaid, the two states would have the same *coverage* metric. For example, a state with low level of poverty will be able to raise its eligibility thresholds and serve a Medicaid population that may still be similar in size (proportional to total number of residents) to that of a state with greater poverty rate but lower Medicaid thresholds.

Summary of Economic Hypotheses:

Economic H1.a: The states' total (including both federal and state) ***costs*** will be positively related to the states' ***per capita income***.

Economic H1.b: The states' total ***costs*** will be inversely related to its ***FMAP***.

Economic H2: State total ***costs*** will be positively correlated with the state's ***poverty rate***.

Economic H3: State ***coverage*** will be negatively correlated with the state's **poverty rate**.

Economic H4: State ***coverage*** will be positively correlated with **per capita income**.

INTEREST GROUP Explanatory Variables:

The public is likely to be most concerned with the total budgetary implications of the Medicaid. The public is likely to be less concerned with the specifics of who or what benefits Medicaid covers; the general American belief that it is inappropriate to get between a doctor and his patients helps shield the public financing of health care from scrutiny. In contrast to this laissez faire attitude, many health care providers have a strong financial incentive to lobby policymakers for their preferred Medicaid policies: their personal incomes and operating revenues are directly impacted by Medicaid reimbursements. For example, Medicaid is the primary source of payments for nursing care: half of all spending on nursing home care and 43 percent of total national spending on long-term care came from Medicaid sources in 2002. The strength of the health care industry is reflected in the fact that five of the ten best funded interest groups in the United States are directly associated with the health care sector: including the American Hospital Association, American Medical Association, Blue Cross and Blue Shield, Pharmaceutical Researchers and Manufacturers of America, and AARP (Center for Responsive Politics, 2011). These associations have a vested interest in expanding Medicaid spending on *benefits* and states with the largest health care sector are likely to experience the greatest amount of lobbying by its health providers. As a consequence those states are likely to have higher *benefits*.

As proxies for the potential lobbying strength of the health care sector I collected data on the number of hospitals and intermediate care facilities as well as the number of doctors working in the state. The facility-related data is from an annual publication, *Hospital Statistics*, by the American Hospital Association (and includes the vast majority of non-profit, for-profit, and state and local government medical facilities whose services are available to the public). The number of doctors is from *Statistical Abstract of the United States*, and originally collected by the American Medical Association. I collected data on the number of hospitals, skilled nursing facilities and beds in both type of facility for each of the states for 11 years in the

dataset. With none of the variables being substantively significant, however, I use *total health care spending* in the state as a proxy for interest group strength of the health care sector in most of the models.

In contrast to their impact on *benefits,* I anticipate the impact of interest groups on *coverage* to be insignificant. Compared to the provider community, potential Medicaid recipients are politically weak and susceptible to the collective action problem when attempting to organize (see Olsen, 1965). Grogan and Gusmano (2007) have considered the variable and unequal influence on the different dimensions of Medicaid policy. The authors have persuasively argued that the poor, especially children, lack consistently vocal policy advocates. Although the federal government has significantly raised the minimum eligibility criteria for Medicaid and every state has complied by expanding their enrollments (with many states exceeding the national minimum rates), the poor, they argue, have not been as well represented in the implementation of Medicaid policy as their increased Medicaid participation would seemingly warrant, particularly at the state-level. [84]

A potential exception to this lack of policy representation and influence among potential recipients, however, is Medicaid's elderly and developmentally disabled populations. These recipients are often described as members of the "deserving poor" and are generally more politically active than the general population. They also have the AARP and other advocacy groups, such as the American Association of People with Disabilities, aggressively lobbying on their behalf for expanded Medicaid benefits that are exceedingly expensive. However, the aged and disabled residents of any state are already more-or-less fully

[84] Complicating the quantitative study is the reality that insuring and providing health care to children, the largest group of Medicaid recipients, is a relatively inexpensive proposition (compared to providing Medicaid to the aged and disabled). Thus, any public advocacy that successfully leads to expanded eligibility for children will likely reduce Medicaid's per beneficiary spending (while only marginally increasing per capita costs of Medicaid). The effect is unlikely to show up in a macro analysis of spending per recipient that group all recipients and expenditures together, such as the following regressions model. The Center for Medicare and Medicaid makes publicly available spending per type of recipient and so future research would do well to look at affects of variables on the separate groups of children, adults, aged, disabled.

insured, either through Medicaid or Medicare, and so efforts by the AARP are more likely to seek enriching benefits rather than expanding coverage. To account for the potential influence of the state's aged population on *benefits* I include the percentage of the state population aged 65 and older. I do not include it as an explanatory variable in the *coverage* model because the aged and disabled account for a small number of total recipients and there is little variability in their eligibility criteria.

Summary of Interest Group Hypotheses:

Interest Group H.1: The proportional number of ***doctors*** in a state will be positively correlated with a state's spending on Medicaid ***benefits***.

Interest Group H.2: The proportional number of ***hospitals*** in a state will be positively correlated with a state's spending on Medicaid ***benefits***.

Interest Group H.3: States with a higher level **of *health-related economic activity*** will have higher Medicaid ***benefits***.

Interest Group H.4: The percentage of state residents' that are ***aged*** will be positively correlated with the states' Medicaid ***benefits***.

PARTISAN (and IDEOLOGICAL) Explanatory Variables:

Medicaid was included in the contentious Social Security Amendments of 1965 that was part of a liberal policy agenda orchestrated by a popular Democrat president and a strong Democrat majority in Congress. In the decades since Medicaid's enactment, however, both parties have more-or-less embraced Medicaid's guarantee of health care to the nation's poorest citizens. It has become an essential social responsibility of federal- and state-governments. Medicaid expansions have historically appealed to

bipartisan coalitions. Each amendment to the Social Security Act that raised Medicaid eligibility criteria in the second half of the 1980s attracted large majorities; as did the original SCHIP legislation and its expansion in 2009 that achieved uncharacteristic bipartisan support. Nevertheless, political ideology and state partisanship are still likely to contribute to the inter- and intra-state variability of Medicaid. Holding all else constant, a liberal public or a Democrat-controlled state legislature will be more inclined to favor spending an additional dollar on Medicaid compared to a conservative public or a Republican-controlled state legislature. Of course, political ideology and partisanship are not equivalent. The median Republican from Massachusetts is likely to have different ideological beliefs than, say, the median voter in a Republican presidential primary. Nonetheless, although a Republican governor of Massachusetts is likely to be more liberal than his colleague in Texas, a local Republican in any particular state will generally be more conservative than his Democrat neighbor. The relative preference orderings between the two parties should be similar throughout the nation. In my models I take into consideration both inter-state ideological variability as well as variability in intra-state partisanship over time.

As a measure of the relative political ideology of a state, I use the Berry et al. *state citizen ideology* score (see Berry et al. 1998, 2007) that is calculated by averaging the interest group rating of the state's congressional representatives and an estimate of each challenger's ideology (estimated as the average ideological rating of the candidates of the challenger's party who were successfully elected elsewhere in the state), weighted by the election returns of the two candidates in the district. The score runs on a 0-1 scale where, 0 is perfectly conservative and 1 is perfectly liberal (I convert the measurement to base 100). The results of the regressions are consistent with using the state presidential vote or average NOMINATE score of the state's two senators. I prefer the citizen ideology, however, score as it more dynamic and available on an annual basis. The state-level partisan explanatory variables are the *% Democrat in Lower Chamber* and *Unified Democrat Dummy* or *Unified Republican Dummy*. The former reflects the two-party share of seats

controlled by Democrats and the latter is a 1 if the governor and both the chambers of the state legislature are all controlled by the respective party (with the exception of Nebraska that is unicameral).[85] I lag all ideological and partisan variables by one year to compensate for delay in implementation of any reforms.

The impact of the voters and legislators' different policy preferences for a certain level of public spending is most likely to show up through policy decisions affecting the dependent variables, *coverage* and *costs*. I expect a positive relationship between *ideology* and *partisanship* with *coverage*. This model posits that conservative publics and/or Republican legislators, who generally desire limiting the size of the public safety net and minimizing federal tax rates, are more likely than a liberals to favor eligibility cuts, lowering *coverage*, that will slow, if not reverse, the marginal growth rate of Medicaid so as to lower the relative *costs* of Medicaid. I do not suspect any significant relationship between either *ideology* or *partisanship* with *benefits*. Although liberal states may be more inclined to offer additional medical services to each recipient, thereby increasing spending per recipient, any eligibility expansion will likely reduce the cost of Medicaid/CHIP per recipient.

Regardless of the temporal policy preferences of voters and state legislators, the ability of politicians to affect change being severely limited by the state's previous policy commitments. The Democrats major health care reform initiative of 2010 exemplifies this tendency: instead of overhauling the health care sector by introducing a single-payer or public option Obamacare relies upon an expansion of Medicaid and existing private insurers to reduce the number of uninsured. Similarly, when Republicans (whether in Congress or the White House) have proposed the draconian reforms necessary to repeal Medicaid, their alternative programs for block granting Medicaid would have left intact the states' and federal-government's significant health-related commitments to the poor. Relatedly, any partisan or

[85] Other variables substituted were: Democrat Governor Dummy (1 if Democrat Governor), % Democrat in Upper Chamber

ideological influence on Medicaid will only be effective at the margins. For this reason I include a lag of the dependent variables in each model.

Significantly, I do not include any federal controls for partisanship. The historical trends with respect to political influence on Medicaid policy are too inconsistent for the following macro level time series analyses. For example, while Reagan successfully lowered spending in the first three years of his administration, any savings were quickly overshadowed by the expansions initiated by a bipartisan group of governors and Democrats in Congress and passed by large majorities of both parties. And it was bipartisan groups in Congress who passed SCHIP. Further, given that each of the dependent variables are measured at the state-level, any federal change will be constant across the states and captured by the year dummies. How a state responds to the federal policy change—allowance of DSH payments, raising the optional eligible thresholds—will be the result of state politics. The independent impact of federal reforms on individual states–such as variability in the Secretary of Health and Human Services' approval of state waivers—will be relegated to the error term.

Summary of Partisan/Ideological Hypotheses:

Partisan H.1a: Traditionally liberal states, with a higher ***citizen ideology score*** will be correlated with greater Medicaid ***coverage***.

Partisan H.1b: A higher ***citizen ideology score*** will also be correlated with higher total ***costs***.

Partisan H.2: The ***percentage of Democrats*** in a state legislature will have a weakly positive relationship with Medicaid ***coverage***.

Partisan H.3: ***Unified Democratic control*** of state government will be positively correlated with ***coverage***; whereas ***unified Republican control*** will have no significant relationship with ***coverage***.

Control Variables

Demographics

A state's Medicaid population is determined by a combination of federal laws that set Medicaid's minimum eligibility thresholds, the state's eligibility standards for its optional Medicaid population, the state's poverty rate and its general demographics. While there remains considerable variation in the eligibility criteria among the states, federal mandates enacted in the later part of the Eighties made certain individuals, particularly children and pregnant women, more likely to be eligible for Medicaid. By 1991, Congress had mandated that states provide Medicaid coverage to all children younger than 6 and pregnant women who had incomes less than 133% of the federal poverty line and for children aged 6 to 18, to 100% of FPL. Approximately 70 percent of Medicaid recipients are eligible due to federal mandates that are exogenous to state policymakers' decisions—including four-fifth of all children and disabled adults, but just one-half of the aged (Kaiser Family Foundation 2005).

I expect that variability in the state's demographics will impact on the state's *Coverage*. Because children are the largest Medicaid population I include controls for the percentage of the state's general population that are *children* aged 18 and under and, as already described in the economic section above, I account for the state's *poverty rate*. As described in interest group section above, I include a control for the percentage of adults aged 65 and older, although there is little variability in the measure across the states.

With a small fraction of all Medicaid recipients accounting for a large majority of the program's total expenditures the demographics of a state and the demographics of the state's Medicaid population will have a significant impact on determining overall spending. Thus, with respect to *Benefits*, I include controls for the proportion of the state's Medicaid population that are *children* aged 18 and under and are *aged or*

disabled. Children are comparatively inexpensive to insure with Medicaid and so states with a greater proportion of children are likely to have lower per recipient charges. For example, in 2008, the average cost of insuring a child was $2,050, ranging from $1,100 in Wisconsin to $3,450 in Massachusetts; im contrast, the average cost of delivering Medicaid to the aged and disabled was $15,910, ranging from $9,200 in Alabama to $29,600 in New York. States with a Medicaid population that consists of a greater than average proportion of *children* should have lower ***benefits*** per recipient; with respect to the proportion of *aged or disabled*, the relationship will be positive. However, precisely because of the high concentration of costs among the aged and disabled and their sensitivity to a multitude of other exogenous factors, the demographic coefficients are unlikely to reach significance in a multivariate empirical study.

In the ***coverage*** model I also control for the percentage of general population that is *black*.

Cost of Health Care

I consider two different proxies for health care costs: average Medicare spending per Medicare beneficiary and total health expenditures per capita, both by state. The Medicare data is available only for 1992 onward and was acquired from the *Dartmouth Atlas of Health Care*. The aggregate health expenditure data is from the Bureau of Labor Statistics and available for the entire time period. Both proxies exhibit significant variation across the states, thereby warranting the inclusion of a control for the local cost of care in the models.

Both data sources suffer a degree of endogeneity with the dependent variables that is unavoidable. While Medicaid finances a share of Medicare charges, the issue is not significant with respect to average Medicare costs and so I ignore any possible complications. However, Medicaid accounts for approximately 15 percent of national health expenditures and so to lessen any potential problems with respect to the net

health care expenditures variable, I subtract the state's net Medicaid expenditures from this total before calculating the amount of non-Medicaid healthcare-related spending per capita

Researchers with the *Dartmouth Atlas* estimate that among groups of Medicare beneficiaries who are otherwise similar, individuals who live in high-spending areas receive approximately 60 percent more in services than do those who live in low-spending areas. The authors found that these differences were due not to differences in prices, average levels of illness, or socioeconomic status but rather to the overall quantity of medical services provided and to the relatively higher proportions of internists and medical subspecialists in high-cost regions. (Fisher et al. 2003) Similarly, a study of regional variation of aggregate Medicare reimbursements by MedPAC (2011) found service use in higher use areas was 30 percent greater than in lower use areas, with the analogous comparison for total Medicare spending being 55 percent greater in high use areas (see also Gawande 2009 and Franzini et al. 2010 on cost variation and physician).[86] Unless there is a substitution affect in which doctors who give more care to Medicare recipients systematically provide less care to Medicaid recipients, it can be expected that states with high Medicare usage and therefore higher costs will also have relatively high Medicaid *Benefits*.

Significantly, Medicaid spending per recipient exhibits greater variability than Medicare spending per enrollee. **Figure 6.9a** and **Figure 6.9b** present the mean, standard deviation and coefficient of variation[87] across the fifty states and the District of Columbia for each year between 1992 and 2009 for

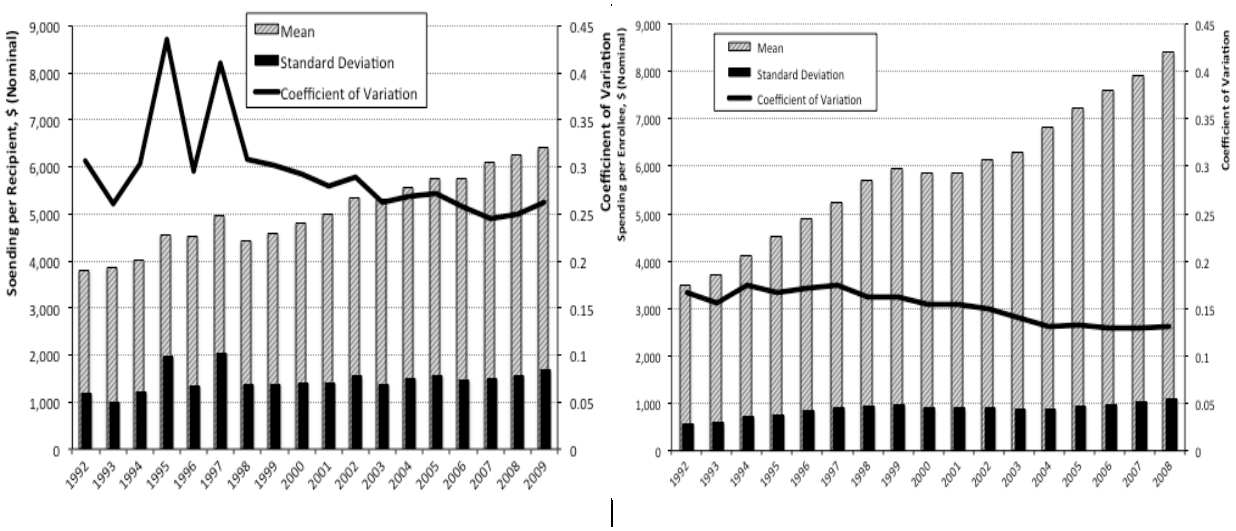
[86] Challenging the general consensus that Medicare spending is a good proxy for total health care spending, Andrew Rettenmaier, and former Medicare Trustee, Thomas Saving, have argued that the state-by-state rankings of per-patient Medicare spending is not strongly correlated with the state rank of total per-capita health care spending (with $\rho = 0.210$; Rettenmaier and Saving, 2010, Table 1; see also Franzi et al 2010 critique of Gawande 2009).

[87] Coefficient of Variation (CV) is defined as the ratio of the standard deviation to the absolute value of the mean of a population: $c_v = \frac{\sigma}{|\mu|}$. Unlike the standard deviation, the coefficient of variation is a dimensionless number. This is preferable for comparing data that may be subject to significant inflation across time or the comparison of two different us, for the across time comparison of data with an increasing means and comparison of two sets of data I use the coefficient of variation instead of the standard deviation.

Medicaid (on the right) and Medicare (on the left), respectively. Between 1992 and 1997, the standard deviation in spending per enrollee, by state, was an average of 230 percent greater with respect to Medicaid compared to Medicare; between 1998 and 2008, the difference in the standard deviations lessened, but the states' Medicare cost per enrollee was still an average of 50 percent greater than the states' Medicaid spending per recipient.

Figure 6.9a. Medicaid spending per recipient, across the States & D.C., FY 1992-2009

Figure 6.9b. Medicare payments per enrollee, across the States & D.C., FY 1992-2009



Sources: Medicare Spending: Dartmouth Atlas; Medicaid Spending: Center for Medicare and Medicaid Services

A factor contributing to the greater variability in the cost of Medicaid compared to Medicare is the fact that latter's reimbursement rates are set federally and are therefore more likely to reflect uniform rate setting standards. With respect to Medicaid, each of the individual states may have different political and economic calculi when determining their reimbursement rates. Additionally, because the federal government is responsible for the full cost and accrues the full savings associated with any marginal change to the rates they have an incentive to set the rates accurately and not bias any particular state.[88]

[88] The federal government may also lack incentives to sufficiently control costs. Whereas the states' balanced budget rules and less progressive tax rates inhibit state expenditures and limit state revenues, federal deficits have rarely imposed any real obstacle to congressional policymaking, including Medicare rate setting. For example, a 1997

Table 6.2 looks at the correlation between a state's Medicaid payments per recipients (i.e. *Benefits*) and its Medicare payments per enrollee: between 1992 and 2008, the coefficient of correlation averaged 0.22, ranging from low of 0.08 in 1995 to 0.41 in 1999. Squaring the correlation coefficient (or R-squared) is equal to the percentage of variation in Medicare payments that is related to the variation in Medicaid payments across the states; less than 5 percent of the variation is statistically related. Thus, despite Medicare showing significant variation, it is correlated with only a fraction of the significantly greater degree of variation in Medicaid across the states.

Table 6.2. Correlation between Medicaid Spending per Recipient and Medicare Spending per Enrollee, across the States & D.C., by Fiscal Year, FY1992-2008

Fiscal Year	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08
Pearson Correlation	.17	.34	.21	.08	.20	.31	.35	.41	.30	.27	.23	.28	.19	.14	.08	.12	.15
R^2	.03	.12	.04	.01	.04	.10	.12	.17	.09	.08	.05	.08	.04	.02	.01	.01	.02

Sources: Medicare Spending: *Dartmouth Atlas;* Medicaid Spending: *Center for Medicare and Medicaid Services*

DSH Payments

In the early 1990s, many states made use of the Disproportionate Share Hospital payments to raise its federal payments without any real increase in state spending. The practice has been reigned in, but still these payments still account for approximately 5 percent of federal Medicaid dollars and increase ***benefits***. Beginning in the late 1990s, Upper Payment Limit (UPL) subsidies were similarly used as a means to collect additional federal revenues. DSH and UPL payments, when coupled with hospital licensing fees, provider

federal law intended to reduce the rate of growth in Medicare was quickly proven to be unworkable (whether for economic reasons or because it was simply politically inexpedient): every year since 2003 the Center for Medicare and Medicaid should have decreased the Medicare physician payment rates given the law's "sustainable growth rate" formulary. However, 12 times in the 8 years between 2003 and 2010 (including five times in 2010) Congress has passed stopgap measures to delay the cuts. The last so-called "doc fix", passing by overwhelming vote of 409-2 in the House after a unanimous consent in the Senate, staved off a 25 percent reduction in Medicare payments and will go through the end of 2012 (when payments, if another doc fix is not passed, will be scheduled to fall 29.5 percent).

taxes and/or intergovernmental transfers, effectively increase the federal share of Medicaid without any of the prerequisite spending by the states. Federal laws are intended to prevent or at least minimize the unmatched use of federal funds for Medicaid purposes, but loopholes persist and the CMS has no way of accurately accounting what proportion of these supplemental payments are or are not recycled back into the states' general revenues.

No good data exists on state level provider taxes or UPL payments (only from fiscal year 2009 and onward are the UPL payments available by fiscal year 2009, by state) and so I only include a control for the amount of DSH per recipient in the model.

Summary of Control Hypotheses:

Control H.1: The share of their ***children enrolled in Medicaid*** will be negatively correlated with ***benefits***.

Control H.2: The percentage of ***children in a state*** will be positively correlated with ***access***.

Control H.2: ***Medicare costs per enrollee*** or ***health care spending per capita*** will be positively correlated with ***benefits***.

Control H.3: ***DSH payments*** will be positively correlated with ***benefits***.

Model Specification

With as many as 29 observations ($T \approx 29$) for each of the 50 states and the District of Columbia ($N \approx 51$), the data is structured as a panel. In panel studies we can break down the error term into two components, the genuine error term ε_{it} and unobservable characteristics of the state, u_i (i.e. there

something about Texas that causes it to have lower Medicaid rates that elsewhere). The repeated observations allow us to draw out these unobserved characteristics. With just one year we can see that New York and Texas vary but we cannot say why. Over thirty years we can see that they consistently vary and with the introduction of explanatory variables we may begin to answer the why.

Panel data analysis endows regression analysis with both a spatial and temporal dimension thereby allowing the researcher to conduct longitudinal analyses on the phenomena of interest—in this case the effect of various explanatory variables on state policies pertaining to Medicaid. The spatial dimension pertains to the set of cross-sectional units of observation, in this case states. The temporal dimension pertains to periodic observations of a set of variables characterizing these cross-sectional units over a particular time span, in this case years. Thus, a state-year constitutes the unit of analysis.

Formally, an empirical model for panel data would examine the relationship between the dependent and independent variables using a two-way model, controlling for the year and state. The two-way *fixed effect* model takes the form:

$$Y_{it}=\alpha + \beta X_{it} + u_i + v_t + \varepsilon_{it}$$

Where α is a constant and X_{it} is (1 x k) vector of k explanatory variables with a three-part error structure.

Fixed effects models are not without their drawbacks. In particular they consume a lot of degrees of freedom. Two-way effect models have two sets of dummy variables for group and time variables (e.g., state and year). With the lag of the dependent variable included, however, I elect to not include a full set of year dummies and conserve the degrees of freedom. Thus, the following models are one-way fixed effect.

I compare my results to a one-way random effects model. The difference between the random effects and fixed effect models is the treatment of the cross-sectional error, u_i, and its variance. In a fixed

effect model u_i is assumed to represent a state-specific effect that is assigned to every state. Conversely, in a random effects model it is assumed there are no state-specific effects and so u_i will be uncorrelated with any explanatory variables that are included in the model.[89]

I conduct a pooled regression model with panel corrected standard errors that includes neither time nor spatial dummies.

Table 6.3 presents an overview of the between-, within-, and overall-group variation among the three dependent variables.[90] The between variation refers to the variation of the mean value for an individual state (ie. heterogeneity between states, due for example to per capita income of state). The within variation refers to the variation in the deviation for a state from their respective mean (i.e. heterogeneity within a state's data across time, due for example to some state-specific policy shock or possibly a measurement error). Overall refers to the whole dataset.

For each of the dependent variables, *costs*, *coverage*, and *benefits*, there was significantly more change over the three decades for a state than there was variation between the states. This is not surprising given all the evidence of the inability of federal legislation to reduce the variation across the states. It supports the decision to focus on the state effect, u_i, and the relatively diminished import of the year effects.

[89] Greene (2003) refers to the random effects model as a regression with a random constant term. However unintuitive this description may be, this 'random constant term'—i.e. the series' intercept—is a random outcome that is a function of a mean value (an unknown constant, *ui*) plus a random error. Similarly, Bartels (2008) uses 'random effects' and 'random intercept' interchangeably.

[90] In Stata, the xtsum command provides some general descriptive statistics pertaining to the overall, between and within variation of the variables in the dataset.

Table 6.3 Variation in dependent variables (Data from xtsum command in Stata).

	Standard Deviation	Proportion of Variation relative to overall variation	Minimum	Maximum	Observations
Cost					
Overall	167	-	10.3	1,183	mean=211
Between	97	.34	81	614	N=1,524
Within	137	.67	-266	780	n=51
					T-bar=29.9
Benefit					
Overall	2,033	-	517	15,586	mean=3,864
Between	1,012	.25	2,408	6,879	N=1,513
Within	1,767	.75	-1,446	14,552	n=51
					t-avg.=29.7
Coverage					
Overall	47.6	-	21.3	320.5	mean=101.6
Between	22.8	.23	62.2	177.9	N=1513
Within	41.9	.77	-10.6	261.2	n=51
					t-avg.=29.7

Note (1): The **proportion of variation** column was constructed by taking square of **between** or **within** variation and dividing it by square of **overall** variation.

Note (2): The Minimum and Maximum columns refer to the extreme demeaned values of the dependent variables. The Within minimum and maximum are the extreme values calculated by taking the data point (i.e. New York *Benefit* in 1990 was X) subtracting the respective state mean (i.e. mean of New York *Benefits* over period was Y) and then adding the overall mean (mean of all *Benefits* was Z). The Between minimum and maximum is equivalent to a data point less the year mean plus the overall mean.

The general specification for my *Cost*, *Coverage* and *Benefits* models are:

$$(1)\ \boldsymbol{Cost_{it}} = \alpha + \beta_1 Cost_{i\text{-}1t} + \beta_2 Coverage_{it} + \beta_3 Benefits_{it} + \beta[Partisan_{i,t\text{-}1}] + \beta[Economic_{it}] + \beta[X_{it}] + u_i + \varepsilon_{it}$$

$$(2)\ \boldsymbol{Coverage_{it}} = \alpha + \beta_1 Coverage_{i\text{-}1t} + \beta[Partisan_{i,t\text{-}1}] + \beta[X_{it}] + u_i + \varepsilon_{it}$$

$$(3)\ \boldsymbol{Benefits_{it}} = \alpha + \beta_1 Benefits_{i\text{-}1t} + \beta[Interests_{1t}] + \beta[X_{it}] + u_i + \varepsilon_{it}$$

Where $cost_{it}$, $coverage_{it}$, and $benefit_{it}$ are the respective dependent variables for state i and year t. $Economic_{it}$ is the vector economic variables. $Partisan_{i,t\text{-}1}$ is the vector of lagged partisan and/or ideological variables; these variables are all lagged a year because of the delay in policy implementation (I tested various

other lags and improvement of fit was not apparent). $Interests_{1t}$ is the vector of Interest Group variables, and X_{it} are various controls, including specified year dummies.

In each model specification, the two-part error structure includes a state fixed-effect, u_i, that controls for permanent differences between states, and a random idiosyncratic error, ε_{it}.[91] I also adjust the standard errors for clustering at the state level (Wooldridge 2001).

I do not include year fixed-effects, v_t, that account for impacts common to all groups but vary year by year; instead I tested specific year dummies.

I have collected data for thirty years, back through 1980, but the lagged dependent variable included in each model reduces *T* by 1. Further, the data is not fully balanced and so *T* varies across the states for certain models, depending on explanatory variables included. For example, Arizona did not join until 1982. I also exclude data from its early years (through 1987), as it is inappropriate to compare Arizona's new program with the mature programs of the other states. I have also dropped certain state-years that are outlying data points.[92] Due to missing values for certain states and years, the dataset is unbalanced.

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[91] The Stata command is: **xtreg** *dependent_variable independent_variables*, **fe i(***index_var***) t(**index_var**),** where the index_var is the variable indicating membership in the group (*i* for group- and *t* for time-fixed effects)

[92] The *benefits* and *costs* outliers that I exclude are: New Hampshire in 1992 through 1994, Hawaii in 1995, and Connecticut and New Jersey in 1997. I exclude these state-years because they are extreme outliers both with respect to the fiscal year and within their group. In the case of New Hampshire, between 1991 and 1992, total Medicaid expenditures in New Hampshire jumped from $390 million to $1.1 billion. In 1993, however, expenditures dropped to $410 million (according to CMS data). Total expenditures then returned to $950 million in 1994, including $360 million in total DSH payments. The CMS' inconsistent accounting of DSH payments seems to be the issue of this odd series. In the early 1990s, New Hampshire legislators discovered the utility of DSH payments, but not until 1994 did the federal financial reports separate out DSH payments. And it would appear they were completely ignored in 1993 in New Hampshire, despite the fact that DSH payments "accounted for more than 50% of all state Medicaid spending, making New Hampshire far and away the national leader in the percentage of Medicaid funds allocated for DSH payments" (Hackey 1998; 188). Indeed, elsewhere, the *federal* DSH payments for New Hampshire for 1991 through 1994 were reported at $25 million, $196 million, $192 million, $190 million.

To minimize the temporal influence of medical and general inflation on Medicaid's *Costs* and *Benefits*, I take the natural log of these dependent variables (as well as *per capita income*, *Medicare spending per enrollee*, and *health spending per capita*) because I suspect the relationship between them is multiplicative in nature (i.e. a increase from $500/capita to $600/capita over one year is comparable to increase of $2,500/capita to $3,000/capita a decade, or two, later—in each case the annual change is 20 percent).

Time Effects

Given the panel structure of the data there is often reason to suspect a dynamic, time-specific effect that is otherwise not accounted for in the marginal changes to the explanatory variable. A now standard modeling practice is to use a Fixed Effects model with panel-corrected standard errors and a lagged dependent variable to account for dynamics (Beck and Katz 1996; Beck 2001; Wilson and Butler 2007), though there is no consensus about this strategy among practitioners (see, e.g., Blaydes 2006; Goodrich 2006).

Having included a lag of the dependent variable I do not include dummies for each state *and* year; however, given the 30-year time span it is reasonable to include specific year-effects. For example, the repeal of the Boren Amendment in 1997 allowed reimbursements to decline with fewer restrictions than previously, the sequential eligibility reforms of the later part of the 1980s, like the CHIP legislation of 1996, increased Medicaid enrollments, and the discovery of DSH payments in 1990 and 1991, like UPL payments a decade later, altered the relationship between the states and federal governments by affecting the fiscal incentives for states to control their overall costs. I test various year dummies, and include those that both improve the fit of the model *and* make theoretical sense.

Fixed versus Random versus Pooled

The data generation process underlying the model specification assumes linearity, independence of observations, the strict exogeneity of the error term, and homoscedastic error variance with no serial correlation. However, a Lagrange Multiplier Test for each of the models that compares the residuals of the model with and without the inclusion of the lagged dependent variable rejects the null hypothesis of independent errors, thereby justifying the inclusion of the lag.[93] This upsets the assumption of strict exogeneity and precipitates the substitution of the more natural assumption of sequential exoegeneity condition on u_i, causing the estimators to become inconsistent.

Given the two-part error structure, the idiosyncratic error term, ε_{it}, is uncorrelated with explanatory variables; but each state may have a state-specific error term, u_i. This means, every state-year observation is subject to a random error unaccounted for by the explanatory variables; but, New York, for example, has *Costs* and *Benefits* that are consistently higher than the 50-state group mean over the entire thirty year period. This not associated with some random error, but something unique to the state of New York that is not sufficiently accounted for among the independent explanatory and control variables (it could be the relative strength of the nursing union or the cost of real estate that are not fully incorporated into the interest group variables or cost of health care variables). The failure to account for this error specifically associated with New York leads to incorrect standard errors and inefficient estimation. The treatment of the state-specific error and its assumed relationship to the explanatory variables determines whether a fixed effects model or random effects model is appropriate.

Pooled OLS

[93] To test for potential autocorrelation, that is the correlation between a variable and its previous value(s), in the model, I use the Stata command corrgram. For each of the primary dependent variables the first lag dominates.

The original recommendation for dealing with time series cross-sectional data offered by Beck and Katz (1995) was to completely pool the data, thereby ignoring any unobserved heterogeneity and use panel corrected standard errors. The Beck-Katz' PCSEs do not make corrections to the standard errors, but the OLS estimates. However, any serial correlation of the errors must be eliminated before PCSEs are calculated. Serial correlation may be modeled by including a lagged dependent variable among the set of independent variables. Although this approach is simple and widely implemented, the ignored hetereogeneity within cross-sectional units can induce omitted variable bias.

With pooled data, the errors tend to have heteroschesdastic variances. For example, a state that sees a lot of political turmoil may have more volatile public policy, or a state that is near the minimum requirements or maximum requirements may see less volatility since they can only move in one direction and that direction would be counter to the states' natural tendencies. By taking the log of certain variables, as I do with the dependent variables for *Cost* and *Benefits,* the impact of any potential temporal heteroschesdaticity is lessened (see Hicks 1994 for summary of complications arising from pooled OLS error estimation).

As a baseline comparison, the pooled OLS model ignores the panel structure of the data and assumes there is no correlation across states, nor across the years for any state. It thus ignores the effect of unobserved features of a state, u, which generates correlation between the values of different years (i.e. the correlation between $u_i + \varepsilon_{i1}$ and $u_i + \varepsilon_{it}$) for each individual state, i.

Pooled OLS assumes constant intercept and slope; although year or state dummies can effectively change the intercept for certain states. Unlike the fixed or random effect models with a lot of cross sectional units it will preserve many degrees of freedom that may be needlessly used up if the variables do not vary within the cross-sectional units. Indeed, Ordinary least squares (OLS) regressions with a full set of n-1 dummies, would, in fact, be a fixed effect model.

Pooling is appropriate when there is no theoretical reason to suspect significant state or temporal effects. Although it is unlikely in a 50-state study that there would not be legitimate state effects (few would mistake the Medicaid policy in Texas with that in Massachusetts), it could be that beyond the variation in explanatory variables the state effects may be insignificant. Or fewer dummies could capture the spatial variation. Instead of 50 state dummies that treat, for example, Connecticut and Massachusetts and Rhode Island as distinctive entities, a compromising approach that preserves some degrees of freedom could be to replace the state dummies in a pooled OLS with more parsimonious regional dummies based on the Census' regions (four) or divisions (nine) that group the preceding states as either part of the Northeastern or New England states. Similarly, year dummies can account for major federal legislative or regulatory changes affecting the dependent variables across the 50 states.

While pooled analysis is a useful instrument for greatly increasing the number of observations, permitting inquiry into variables that are largely time-invariant, and, as a result, the development of comparative theory, its substantive popularity has been challenged on methodological grounds. Stimson 1985, Hicks 1994, Beck and Katz 1995, 1996 point out that pooled time series analysis violates the standard OLS assumptions about the error process—that all errors have the same variance and are independently of each other. In fact, the OLS regression estimates, used by social scientists commonly to link potential causes and effects, are likely to be biased, inefficient and/or inconsistent when they are applied to pooled data.

Fixed Effect Model

The Medicaid dataset includes the full set of states and as such a fixed effect model is appropriate for the panel because the cross-sectional units are "fixed." Like a regular OLS model, a fixed effect model will have constant slopes for each of the explanatory variables across the cross-sectional units, in this case, the state. The intercepts, however, can differ for each of the states. Because $i - 1$ dummy variables are

included to designate each of the states, this model is also referred to as the Least Squares Dummy Variable model

With panel data it is important to be cautious of potential auto-correlation owing to time-lagged temporal effects. As I have argued elsewhere, the path dependency nature of public policy makes it reasonable to suspect that any error in period *t* for state *i* will be present for period *t + 1* for the same state *i*. Two ways of dealing with this is through an auto-regressive parameter (AR1) or with the inclusion of a lag of the dependent variable on the right-hand side of the equation. Given that nearly every series are unidirectional with *Costs*, *Benefits* and *Coverage,* a moving average model (constructed by 'demeaning' the data) would be inappropriate because the mean will overestimate the first half of every series and underestimate the second half of the series. Further, Beck and Katz (2004) argue there is little reason to prefer the auto-regressive parameter to a lag.

Random Effect Model

In a random effects model, the intercept is a random outcome variable that is function of a mean value and a random error. The state-specific error terms are not estimated directly; rather the random effects estimate the mean and variance of a distribution of u_i. Thus, while $u_i + \varepsilon_{it}$ represent the random part of the estimation, the actual parameters being estimated are σ_u^2 and σ_ε^2, not $u_i + \varepsilon_{it}$. This allows us to interpret variances not individual state effects: σ_u^2 is the unexplained variation at Level-2, i.e. between states, after controlling for all explanatory variables, and σ_ε^2 is the unexplained Level-1 variation, i.e. within states, after controlling for explanatory variables.

For random effects to be modeled the (unobserved) cross-sectional error term, u_i, must be uncorrelated with the individual error terms, ε_{it}. In this case, the cross-sectional error term would have to

be constant across the 30 years of data and heterogeneous to a state (Yaffee, 2003). Very reasonably, this assumption that the random effects term, u_i, is uncorrelated with the explanatory variables (i.e. Cov(X_{it}, u_i) = 0) is unrealistic, making the Fixed Effects model theoretically superior.

Further, the random effects model reflects a loss of information to the model, but as I am primarily interested in the effects of the specific explanatory variables and not the state-specific effects, a random effects model may be appropriate. For example, in the case of the effect of state ideology on *Coverage*, the dependent variable is *Coverage*, the explanatory variable of interest is state ideology and the state is treated as a control variable and random effect. (see Littell et al. 2002; Hanneman, n.d.).

A random effects model has the "distinct advantage of allowing for time-invariant variables to be included among the regressors"(*Ibid.*). Any heterogeneity that is function of time-invariant variables will be absorbed by the cross-sectional intercepts and so the influence of time-invariant variables cannot be separated. Though not perfectly invariant, the slow changing variables for ideology, certain health care-related variables (such as hospitals and doctors), and demographic characteristics justify the consideration of a random effects model. Such time invariant variables impact the assumption that the cross-sectional error terms, u_i, are orthogonal to, or uncorrelated with, the individual error terms, ε_{it}. Because several of my explanatory variables of interest do not vary significantly over time the fixed effect model is computationally inappropriate.

Results

For each dependent variable (*costs, benefits* and *coverage*), I compare the several models. The first model in each case is a completely pooled model (OLS) approach with a lagged dependent variable and panel corrected standard errors. I run the Breusch-Pagan Lagrange multiplier test to compare the results

from the pooled OLS models to those from the Random Effects models (Breusch and Pagan 1980). For each of the dependent variables the tests reject the assumption that the cross sectional variance components, u_i, are zero; therefore, suggesting that the random effects model is preferable.

To compare the Fixed Effects model to the Random Effects model I perform the Durbin-Wu-Hausman specification test (Hausman 1978). It tests the null hypothesis that the individual errors are uncorrelated with the other regressors in the model. A large and significant Hausman statistic means a large and significant difference between the two models, and so one can reject the null hypothesis that the two methods produce similar coefficients in favor of the alternative hypothesis that the Fixed Effect model is preferred to the Random Effects model, with the latter producing biased estimators (therefore violating Gauss-Markov assumptions).[94] The results of the tests suggest that the fixed effects models are more appropriate.

Table 6.4 through **Table 6.6** present the results for the *benefits*, *coverage*, and *costs* models, respectively.

[94] The Stata commands for the Hausman Test are as follows (where *y* is the dependent variable, and *x1*, *x2*, etc. are the model's explanatory variables including lags and dummies):

xtreg *y x1 x2*, fe
estimates store *fixed*
xtreg *y x1 x2*, re
estimates store *random*
hausman *fixed random*

Table 6.4. *Benefits* Model

Dependent Variable: Total Medicaid Spending per Medicaid Recipient (Unduplicated Count)

	Pooled OLS	**Random Effects**	**Fixed Effects**		
	(1)	***(2)***	***(3)***	***(4)***	***(5)***
Ln(**Benefits**)$_{t-1}$	.8151*** (.0322)	.7731*** (0.0155)	.7300*** (.0293)	.4071*** (.0313)	0.6094*** (0.0213)
Ln(**Health Income per Capita**)	.1217*** (.0272)	.1906*** (0.0188)	-	-	0.252*** (0.0225)
Ln(**Medicare per Enrollee**)	-	-	-	.3184*** (.0388)	-
Hospitals per 100,000	-	-	-.0551*** (.0216)	-	-
Nursing Homes per 100,000	-	-	.0139*** (.0040)	-	-
% over 65	-.0004 (.0018)	.0076*** (0.0010)	.0018 .0021	.0169*** (.0024)	0.0217*** (0.008)
SSI Enrollees per 100	-.0094** (.0039)	-.0146*** (.0054)	.0690*** (0.0278)	-.0076 (.0293)	0.0626*** (0.0184)
AFDC Enrollees per 100	.0036 (.0029)	.0064*** (.0028)	-.0248*** (.0076)	-.0153*** (.0059)	0.0046 (0.0035)
Interaction: **1990 Dummy** × **AFDC Enrollees** per 100	-.0118** (.0053)	-.0284*** (.0064)	-	-	0.0229*** (0.0067)
FMAP		.0007 (.0005)	.0012 (.0024)	-.0011 (.0028)	0.0007 (0.0016)
Citizen Ideology Score$_{t-1}$	.0003 (.0003)	-.0002 (.0004)	.0028*** (.0009)	-.0001 (.0009)	-0.0004 (0.0006)
Institutional Ideology Score$_{t-1}$	-.0004** (.0002)	-.0004** (.0002)	-.0002 0.0003)	-.0004 (.0003)	-0.0004* (0.0002)
Constant	.6936*** (.1203)	.4294*** (01118)	2.0800*** (.2873)	2.2412*** (.4005)	0.9998*** (0.1343)
Variance: σ_u	-	-	.1245	.1226	0.1189
σ_ϵ	-	0.1162	.0960	.1171	0.1251
ρ	-	-	.6273	.5225	0.4744
$\mathbf{R^2}$: within	-	0.9416	0.9454	.6476	0.9366
between	-	0.9787	0.7186	.8786	0.7815
overall	0.9411	0.9478	0.8841	.7526	0.9022
Total observations (***N***)	1339	1289	448	750	1339
Average ***n***	50	50	50	50	50
Average ***t***	26.8	25.8	9	15	26.8

Table 6.5 *Coverage* Models

Dependent Variable: Number of Medicaid Recipients (Unduplicated Annual Count) as a Share of the Number of Residents Living in Poverty (base 100)

	OLS with PCSE (1)	Random Effects (2)	Fixed Effects (3)
$Coverage_{t-1}$	.7352***	.7352***	.6583***
	(.0278)	(.0151)	(.0172)
Poverty Rate	-3.431***	-3.431***	-5.6954***
	(.3436)	(.2180)	(.2886)
SSI Rate	11.1950***	11.1950***	10.4219***
	(1.2183)	(.8822)	(2.3831)
Unemployment Rate	.9575**	.9575**	2.8396***
	(.4410)	(.3271)	(.4140)
% Population under 19	.8818***	.8818***	-1.5577***
	(.2380)	(.2529)	(.5223)
% Population on AFDC	-1.7965***	-1.7965***	-1.8146***
	(.5398)	(.4187)	(.5619)
Recession Dummy	-1.7589	-1.7589	.1118
	(1.9269)	(1.1404)	(1.1110)
Post-1990 dummy	1.1931**	1.1931***	1.0555***
	(.4753)	(.3108)	(.3818)
Post-1996 dummy	3.1683***	3.1683***	3.1633***
	(.7867)	(.5163)	(.5317)
$Citizen\ Ideology\ Score_{t-1}$	.1047*	.1047**	.2451***
	(.0591)	(.0529)	(.0806)
$Institutional\ Score_{t-1}$	.0526	.0526	.0227
	(.0388)	(.0404)	(.0409)
Unified Democrat	.2360	.2360	2.186
	(1.4788)	(1.3866)	(1.4647)
Unified Republican	.3082	.3082	-2.0050
	(1.6000)	(1.7878)	(1.8520)
Constant	14.0346*	14.0346*	106.2842***
	(8.1160)	(8.4749)	(17.1738)
Variance: σ_u		0	12.6068
σ_ϵ		15.6426	15.6426
ρ		0	0.3938
$\mathbf{R^2}$**:** within	-	0.8527	0.8638
Between	-	0.9532	0.8206
overall	0.8761	0.8761	0.8351
Total observations (***N***)	1318	1318	1318
Average ***n***	50	50	50
Average ***t***	26.4	26.4	26.4

Table 6.6. *Costs* Model

Dependent Variable: Natural log of State-Share of Medicaid Costs per Capita

	OLS with PCSE		Random Effects		Fixed Effects	
	(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**
Ln(**Benefits**)	.9991***	.6877***	1.0874***	.8174***	1.091***	.8210***
	(.0246)	(.0326)	(.0119)	(.0248)	(.0119)	(.0253)
Ln(**Coverage**)	.0068***	.0046***	.0053***	.0038***	.0053***	.0037***
	(.0003)	(.0003)	(.0001)	(.0002)	(.0001)	(.0002)
Ln(**Per Capita Income**)		5.6740***		4.9941***		5.0424***
		(.5337)		(.4051)		(.4144)
FMAP Dummy		.0195		.0443**		.04382***
(1 if FMAP = 50)		(.0148)		(.0181)		(.0187)
Recession Dummy		.0002		.0099		.0098
		(.0006)		(.0100)		(.0099)
Citizen Ideology Score$_{t-1}$		.0058***		.0028***		.0022***
		(.0006)		(.0006)		(.0007)
Constant		-14.36***	-4.333***	-13.62***	-4.36***	-13.73***
		(1.08)	(.092)	(.74)	(.087)	(.75)
Variance: σ_u			.2006	.1664	.2246	.1904
σ_ϵ			.1795	.1630	.1795	.1630
ρ			.5555	.5101	.6103	.57770
$\mathbf{R^2}$**:** within	.8954	.9231	.9462	.9560	.9462	.9561
between			.6895	.7535	.6874	.7452
overall			.8906	.9167	.8902	.9150
Total observations (***N***)	1512	1438	1512	1438	1512	1438
Average ***n***	51	50	51	50	51	50
Average ***t***	29.6	28.8	29.6	28.8	29.6	28.8

Discussion and Conclusion

Admittedly, the multi-variable regression analysis appears of limited utility. Nevertheless, the results from each of the multivariable models accord, for the most part, to the hypotheses introduced earlier—though the substantive effects are not always intuitive given that some of the dependent and explanatory variables have been transformed with the natural log function. I will interpret some of the results to help demonstrate the observed relationships.

The predictive power of the models is diminished by the importance of the lag dependent variable and the fact that this variable in absorbing much of the explanatory force of the models. In each of the *benefits* and *coverage* models the lag dependent variable, as expected, has the highest predictive power. An alternative approach to accounting for time-dependent nature of the data is to transform the data to reflect year-to-year changes, so that the dependent variable reflects only the change—either in absolute terms or as a percentage. This, however, would have a similar affect of reducing the potential impact of any explanatory variable since only a small portion of total spending or benefits or enrollments would be explained. Given the nature of the panel data and the assumptions of the models that must be met, this is unavoidable. That many of the variables remain significant, however, is noteworthy.

A lag of the *cost* dependent variable is not included in the *costs* model. Such a lagged variable is redundant because the *cost* models already include the *coverage* and *benefits* variables and demonstrated in their respective models, these two dimensions of Medicaid policymaking are largely determined by the states' past policy decisions. Therefore, I assume by including *coverage* and *benefits* in the *costs* model, the policy effect of time on overall spending is already accounted, if indirectly so, in the model's construction.

With respect to the overall *costs* models, the states' policies establishing their *benefits* and *coverage* are positively correlated with higher expenditures. Based on the estimated substantive impact of the two

variables it would appear that higher expenditures per recipient (i.e. *benefits*) has a greater impact on raising Medicaid expenditures than does the expansiveness of access to Medicaid services (i.e. *coverage*). It could be that states with higher proportion of their poor (and near-poor) enrolled in Medicaid have learned to deliver a more efficient Medicaid/CHIP program, either by reducing reimbursements to providers and hospitals or offering less expansive benefits.

It is worth noting that the Affordable Care Act will significantly expand coverage across most states, but so long as implementation of the Medicaid expansion is uneven there could be a period of increased variability. Based upon what states have announced that they will participate in the Medicaid expansion, it is likely that states' ideological score and institutional score will become more significant, at least temporarily. This hypothesized pattern would contrast, at least superficially, with the states' willingness to implement CHIP in 1997. In their study of the determinants of changes in the average income eligibility levels (as a percent of the federal poverty level) for states between 1997 (pre-CHIP) and 2000 (post-CHIP), Ullman and Hill (2001) find that changes in the federal matching rate and party control of governorship and legislature are not significant. Consistent with some of the findings from the *coverage* model, Ullman and Hill find the only significant effects in their model to be the initial eligibility level, per capita income and fraction of children uninsured in 1997.

As the states implement the Medicaid expansion (assuming they ultimately do so), variability in *coverage* should diminish, thereby lessening the impact of eligibility criteria on a state's overall *costs*. Though some states will continue to be outliers with respect to the access that their residents have to Medicaid, the federalizing of eligibility criteria (to 133% of poverty across the nation) will mean that Medicaid benefits and reimbursement rates, as well as the specific demographics of their Medicaid population, will be the

primary determinants of variation in spending.[95] States that are able to deliver Medicaid most efficiently should be able to more effectively control their spending per capita. However, the impetus for states to reduce there own share of *costs* will likely be mitigated by the fact that the federal government will fully finance 100 percent of the cost of newly eligible Medicaid recipients up to 133 percent of poverty (with the federal share declining to 90 percent by 2019).

As expected, a state's per capita income had a significant and substantively positive impact on *costs*: this is intuitive because states with higher incomes have a lower FMAP rate and therefore must pay for a larger proportion of their total Medicaid costs controlling for total spending. This is the intent of Medicaid's funding formula, to raise the level of spending in lower income states than it would (or could) be otherwise. That the *FMAP dummy* (the variable is set to 1 if the state had the minimum FMAP rate of 50 percent) was also positive and significant suggests that the federal minimum matching rate inflated states spending more than would have been the case if the state-share of Medicaid spending was defined strictly by the state's level per capita income alone.

As an alternative construction for the dependent variable, *costs*, I substitute total Medicaid spending in lieu of just the state-share of Medicaid spending—the high level of endogeneity between this alternative *costs* and *benefits* make this model inappropriate for a general analysis. With the alternative *costs* variable, state-level income per capita remained significant and positively correlated, but its substantive impact lessened greatly. This diminution in the observed relationship between net spending per capita and income per capita suggests that the federal cost sharing formula reduces the potential inequities in the states'

[95] The Affordable Care Act mandated that every state participating in Medicaid would need to expand eligibility up to 133% of poverty based on modified adjusted gross income of the household. As part of its ruling for the case known as *National Federation of Independent Business v. Sebelius* 567 U.S. ___ (2012), the Supreme Court considered the constitutionality of two provisions of the Affordable Care Act: the individual mandate and Medicaid expansion. The Court upheld the constitutionality of the former, but ruled the Medicaid expansion was unconstitutionally coercive. However, it is reasonable to expect that most, if not all, states will eventually acquiesce and expand coverage given the very favorable federal match of 100% initially, dropping to 90% in 2020 and prospectively).

commitments to Medicaid that could otherwise be expected given the variation in the states' relative fiscal resources. Nonetheless, the persistence of a still significant level of variability in net *costs* (see **Figures 7.1** and **7.2** above) that can be attributed to state-level per capita incomes suggests that Medicaid's cost sharing formula does not sufficiently reflect the states' different abilities to pay for Medicaid.

The data tends to support the argument that Medicaid manages to escape the ideological and partisan wrangling that typically surround the politics of welfare policy in the United States, with the relationships between each of the dependent variables and the political and ideological variables being muted. For the most part, the quantitative analysis would appear to support the observation that Medicaid exemplifies path dependency and its observation that policy development is more-or-less exogenous to the political process, with policy being determined largely by past policy choices. For voters concerned about the fiscal commitment of Medicaid this lack of relationship to citizen ideology and the changing ideological representation of state legislatures could be troubling.

In each fixed effects model the *citizen ideology score* is in the positive direction as predicted, with a higher ideology score according to greater *costs*, more generous *benefits*, and broader *coverage*. However, in the *benefits* (fixed effects) model the effect is overwhelmed by other factors and is not always significant nor in the positive direction. In the *costs* model, the *citizen ideology score* variable is significant, but exhibits no substantive impact. Only in the *coverage* model does citizen ideology appear to be significant and have a substantive impact—according with the hypothesis that voters are most cognizant of eligibility criteria, with liberal states expressing a preference for more expansive coverage (compared to benefit levels or marginal costs).

Similarly, the *institutional score*$_{t-1}$ is not substantive in most of the models in which it is present. Despite the study's descriptive data and much anecdotal evidence demonstrating that states annually make

adjustments to their Medicaid policies over time, three decades of quantitative data suggests that such changes exhibit no consistent relationship to partisanship. While unified Democratic control of the state legislatures may lead to a liberalizing of enrollment, as indicated by the positive coefficients on both the *unified democrat* dummy variable and the positive direction of the *institutional score* in the *coverage* model, the coefficients on neither variable are significant. In general, therefore, it would appear that state-level ideology or partisanship does not determine policies that establish Medicaid coverage and benefits criteria. Such a statement may appear somewhat counterintuitive—particularly given the generosity of Medicaid programs in such avowedly liberal "Blue" states as New York, Connecticut, Massachusetts. However, what may be more appropriately characterized as a regional pattern could be caused by the similar combination of relatively high per capita income and high medical costs in these states as opposed to partisanship. While local ideology is not incidental, the data suggests it is not sufficiently causal.

In general, the statistical analyses demonstrate the difficulty of abstracting the complexities of a public policy to fit a few variables. The apparent singularity of the state-level Medicaid policies that the quantitative study suggests calls forth Theda Skocpol and Kenneth Finegold's notion of *state capacity* as potential theoretical approach to studying Medicaid policy. Introduced in a 1982 essay that looked at the divergent histories of two contemporaneous New Deal programs—the National Industrial Recovery Act and the Agricultural Adjustment Act—Skocpol and Finegold's theory of state capacity discounts the explanatory value of traditional socio-economic variables for understanding the relative success or failure of different public programs. Instead, Skocpol and Finegold attribute variation in the implementation of policy to the abilities and hard work of skillful bureaucrats and presence of experienced political institutions. Drawing upon Hugh Heclo's idea of policy learning, Skocpol and Finegold recognize that the successful implementation of a public policy is dependent upon the state's "capacity to draw upon administrative resources of information, analysis and expertise for new policy lessons and appropriate conclusions on

increasingly complex issues" (1982: 277-78; quoting Heclo 1974: 305-06). They argue for the need to "go beyond the social-determinist proclivities of conventional pluralism and conventional Marxism alike" (1982: 260). Such a broad perspective may be needed to understand a policy as complex as Medicaid. Unfortunately, a meaningful measure of state capacity is difficult to capture quantitatively and would require thick descriptions of multiple case studies—such an endeavor lies outside the scope of the central theme of this dissertation.

Michael Sparer's (1996) excellent comparative case study of New York and California's Medicaid programs support the Skocpol and Finegold thesis in relationship to Medicaid policymaking. Although New York and California are similarly wealthy and have comparable partisan leanings, the two states have historically committed significantly different levels of resources to their Medicaid programs, particularly with respect to the level of spending per recipient—with California generally spending half the amount per capita as New York. Sparer attributes the divergent paths of these two states to the level bureaucratic autonomy of state Medicaid offices. Future research, mine included, might want to similarly pursue qualitatively rich case studies that comparatively examine divergent policymaking patterns between states so as to explore and better understand the causal influence of more refined variables in relationship to Medicaid's funding streams.

Future Research

Linear Random Intercept Model

Given the indecision over whether or not to accept the Random Effects model or Fixed Effect model, future modeling efforts could consider Bartels' "unified" approach to modeling times series cross-sectional data (see Bartels 2008). He refers to his so-called unified approach as a random intercept model,

estimated by feasible generalized least squares (FGLS). Bartels argues that the model corrects for cluster confounding, thereby allowing for time-invariant variables (e.g. certain state-level data such as a state's ideological score) and unobserved heterogeneity (e.g. provider taxes that may be correlated with DSH/UPL payments and total spending) while still satisfying the assumption that explanatory variables be uncorrelated with the random effects term. Bartels explains, "Cluster confounding occurs when a level-1 variable (e.g., a time-varying covariate in panel and TSCS data) exhibits distinct within-cluster and between-cluster effects, yet one only includes the original level-1 variable in the model without distinguishing these two types of variation in that variable" (*Ibid.*).

In my Medicaid dataset, a cluster is defined by the state. Thus, *Benefits*, for example, can vary *within* any individual state over the 30 years; *Benefits*, however, can also vary at any point in time *between* the states. *Benefits*, or any explanatory variable, could potentially exhibit very distinct within- and between-cluster effects. For example, the number of hospitals per 100,000 may have a null within-state effect on *Benefits* (i.e. as the number of hospitals in a state falls, as has been the trend across almost all the states, there has been no causal effect on the state's reimbursement rates), but a positive between-state effect on *Benefits* (i.e. states with more hospitals typically have higher reimbursement rates). The fixed effect model would only capture the null within-state effect, while the complete pooling and random effects model would assume the within- and between- effects are equal. This is an example of cluster cofounding—when the different within- and between- effects of the explanatory variable on the dependent variable cannot be distinguished. If the two effects are equal it is not a problem, but if they are not equal ignoring the issue will lead to incorrect interpretation of the model's coefficients (Bartels 2008, 9; Zorn 2001).

Chapter 7.

Medicaid's Fiscal Burden, a Taxpayer and State Perspective

The public cost of Medicaid and CHIP is often presented in the aggregate: in 2008, spending totaled approximately $362 billion, or $1,150 per capita, with the federal government spending about $208 billion to match the states' spending of $153 billion. In the previous chapter, the dependent variable of the *costs* model was a per capita measure of state-level spending, ranging from $507 in Utah to $2,443 in New York for fiscal year 2008.

However, what the nation or state spends on Medicaid/CHIP on a per capita basis is vastly different than what individual Americans pay for Medicaid/CHIP in the form of their direct tax liabilities for the program. As a redistributive program financed by general revenues, a more appropriate proxy of Medicaid's cost might therefore be the proportion of total costs that a typical taxpayer is implicitly responsible for financing. Taking this perspective, and defining a taxpayer as an American aged 18 through 64 with earnings twice the poverty line, the average American taxpayers' burden for the nation's Medicaid/CHIP commitment was actually closer to $2,270 in 2008. Or, if we were to approach Medicaid from a state perspective, total spending on Medicaid/CHIP ranged from $253 in Nevada to $1816 in New York, on a per taxpayer basis, in 2008.

Yet, these estimates still obfuscate the discrete cost of Medicaid to the American taxpayers by ignoring the distribution of those costs, both at the individual level by and across the states. Using 2007 and 2008 data from the IRS, the non-partisan Tax Foundation, and the Center for Medicare and Medicaid, this chapter presents more precise estimates of (a) what state-residents *cum* federal taxpayers contribute toward

Medicaid/CHIP, and (b) what Medicaid/CHIP costs the states as a discrete political entities by taking into consideration the interstate transfer of federal tax dollars associated with Medicaid cost sharing.

Medicaid's Taxpayer Burden

To calculate the direct cost of Medicaid from the perspective of the taxpayer it is prudent to disaggregate total spending into its two components—the federal- and state-shares—to reflect the different revenue generation models of these distinct levels of government. With respect to the first component, I estimate the federal-taxpayer burden of the federal-share of Medicaid/CHIP by taking into consideration the progressivity of the federal tax code. With a small portion of Americans paying the vast majority of all federal personal income taxes, any meaningful individual-level estimate of the cost of the federal-share of Medicaid expenditures must consider the the distribution of tax liabilities. This variable proxy adjusts aggregate federal Medicaid/CHIP spending to reflect the proportion of general expenditures actually financed by current individual income tax receipts by controlling for deficit financing, corporate income taxes, and the progressivity of the United States tax code.

For the second component of the calculation, I shift my attention to the state-taxpayer burden associated with the state-share of Medicaid/CHIP. In contrast to federal income tax liabilities, the relative regressivity of the states' revenue generating mechanisms makes calculating a variable proxy for each state less essential. As such, the mean estimate of the state-share of costs on a per state-taxpayer basis remains a more-or-less legitimate proxy for establishing the taxpayer burden in a state. I will further adjust the state share of Medicaid spending by reducing it by the proportion of state revenues levied on tourists and interstate commerce so that the state-share reflects only the direct cost to state residents.

The Federal-Taxpayer Burden of Medicaid/CHIP

Medicaid/CHIP spending totaled $362 billion in fiscal year 2008, of which the Center for Medicare and Medicaid reimbursed $208.4 billion to the states (and territories). To put this spending into the context of the federal budget, Medicaid/CHIP was the third largest domestic expenditure commitment of the federal government, excluding military spending.

By commanding about 7.0 percent of the near-$3 trillion in federal spending during 2008, Medicaid was behind just Social Security and Medicare in terms of aggregate costs. Yet, Social Security with $625.2 billion in total disbursements, and Medicare with $468.1 billion in payments, had nearly all, as in the case of Social Security and Medicare Part A (hospital insurance), or at least a significant portion, as in case of Medicare Part B (supplemental health insurance) and Part D (prescription drug coverage), of their total expenditures balanced with dedicated revenue sources that are funded, either directly or indirectly, by their beneficiaries.[96]

The Social Security Administration make explicit the individual tax burden of the costs associated with these two social insurance programs. Each year, working Americans receive a personalized *Your Social Security Statement* from the federal government that summarizes how much they and their employers contributed toward Medicare and Social Security: a household earning the median income of $52,029 in 2008 paid approximately $3,225 in Social Security taxes and $750 in Medicare taxes (both matched by their employer). Medicare beneficiaries over 65 (and those under 65 who are disabled and eligible for Medicare)

[96] In fact, after summing all the receipts from the employment tax contributions, the income derived from taxing Social Security benefits and the interest earned on the accumulating balances of the OASI and DI Trust Funds, the federal government netted $179.3 billion for the Social Security Trust Fund, bringing their combined reserves to $2.4 trillion at the end of 2008. And although the dedicated funding sources for Medicare, which included $198.7 billion in payroll taxes and $58.2 billion in premiums paid by current beneficiaries, are not as comprehensive as those for Social Security, the impact of Medicare on the general tax revenues of the federal government was *just* $184.4 billion, or about 40 percent of the total Medicare bill (not factoring in the net $12.7 billion gain that was added to the Medicare Trust Funds).

paid monthly premiums of $96.40 for their Part B insurance and an average of $32 for their Part D coverage that added an additional $1,519 in dedicated federal revenues per senior per annum.

Unlike these two entitlement programs that have their own dedicated revenues sources, the federal revenues required to finance the poor's entitlement to comprehensive health care services come entirely from general revenues. Significantly, Medicaid/CHIP consumes nearly 20 percent, one in every five dollars, of all non-military related general spending not financed with dedicated revenues. As serious as the threats of the potential insolvency of the Medicare may appear—the latest report from Social Security and Medicare Boards of Trustees [2010] estimated the "solvency" of Medicare Trust Fund through 2029—Medicaid's costs pose as great a, if not greater, fiscal challenge for the federal budget each year.

Without the equivalent of a *Your Medicaid Statement* quantifying the public's fiscal commitment to Medicaid, there is little public understanding of what Medicaid costs the nation, and more specifically, costs individual American taxpayers. However, if every American was provided with a federal receipt that totaled the net federal taxes they paid, if any, and itemized the proportional share of the programs their taxes financed, there would be vast disparities among what Americans contributed. After accounting for all tax deductions, credits, and refunds, many taxpayers would have had a tax liability that was negative or near zero tax in 2008 and consequently paid nothing or very little for most government services, including Medicaid/CHIP. In calculating Medicaid's federal-taxpayer burden then, it should be recognized that not all Americans pay federal taxes.

Further, while individual income taxes are a significant share of the federal government's income, they are not the only source of public revenues. The above mentioned payroll taxes account for about a third of all revenues, and another fifth come from corporate profits, excise charges such as a gasoline fuel tax, estate taxes, and other taxes or fees. To get a more accurate estimate of the individual taxpayer burden imposed by a redistributive program like Medicaid it is necessary to have a better accounting of not only

who pays—that is, the number of Americans who have a positive tax liability and thereby finance a proportion of the federal government's current operations—but *how much* this subset of taxpaying Americans pay—in this case, the proportion of the net federal-share of Medicaid/CHIP financed by individual tax receipts and the distribution of the net tax liability across income levels.

Calculating the Federal-Taxpayers' Adjusted Share of Medicaid/CHIP Spending

In estimating the proportion of Medicaid/CHIP expenditures directly financed by the public, I assume the share of spending financed from general revenues is equivalent across all government programs. I calculate this amount by disaggregating the federal government's total general spending into the share that can be reasonably assumed to having been financed by the individual income tax receipts collected by the IRS.

Total public spending reported by the federal government, including the two supplemental appropriation requests for military operations in Iraq and Afghanistan (totaling $189 billion) totaled $2.983 trillion in FY 2008. That calendar year, the Internal Revenue Service reported total revenue collections of $2.742 trillion (I ignore any complications caused by the fact that the U.S. Treasury's fiscal year leads the IRS' calendar year by three months—the Congressional Budget Office (2009) reported the federal government collected $2.524 trillion in revenues in fiscal 2008). Individual income taxes accounted for $2.307 trillion. However, embedded in the individual income tax data are all employment-related FICA taxes designated for Social Security and Medicare. In 2008, these totaled $883.1 billion. As these revenues are earmarked for specific entitlement programs, excluding them as a potential source of Medicaid funding is prudent. Doing so leaves the federal government with $1.424 trillion of uncommitted general revenues.

In ignoring all FICA taxes, it is important to also reduce net federal expenditures by the $971 billion of Social Security and Medicare spending financed by these payroll taxes and other dedicated revenues (such as beneficiary premiums and interest earnings). Excluding this entitlement spending reduces federal general expenditures to $2.012 trillion.

Thus, the $1.424 trillion of uncommitted individual income taxes collected in 2008 funded 70.8 percent of the federal governments' $2.102 trillion in general expenditures.[97] Other federal taxes (corporate income taxes totaled $352.9 billion and estate, gift and excise taxes added $81.4 billion), federal charges and user fees, and debt, financed the remaining 29.2 percent of the government's current general operations. Accepting that all forms of general revenues are used to finance equal proportions of the government's various public commitments then individual federal income tax receipts directly offset 70.8 percent, or $145.8 billion, of the $206.1 billion federal-share of Medicaid/CHIP spending.

Table 7.1 summarizes the calculations made to arrive at the percentage of general spending financed by individual federal income taxes.

[97] This is a rough proxy of individual tax burden for the federal government's general spending. On the one hand, I could treat federal revenues similar to how the CBO does and assume a unitary budget that does not give any special consideration to the intragovernmental transfers of expenditures (in which case total individual income tax collections, net of all FICA contributions, accounted for 77.3 percent of cumulative federal spending). On the other hand, there are other expenditures with dedicated funding sources that are not accounted for in the personal income tax figure but are remain in the expenditures figure: for example, I could decrease general federal spending by the $48.4 billion collected primarily through an 18.4 cent per gallon fuel tax and earmarked for the Highway Trust Fund distributed to the states.

Table 7.1 Calculating Taxpayer Burden as a Percent of Total Federal Spending

REVENUES	
Total Federal Tax Collections	$2,742.2
Individual Income Taxes	2,306.6
Less Payroll Taxes	
Old Age and Survivors Insurance	(574.6)
Disability Insurance	(97.6)
Hospital Insurance	(198.7)
Railroad Retirement Taxes	(4.9)
Unemployment Insurance Taxes	(7.3)
Individual Income Taxes available for General Expenditures	**1,423.5**
EXPENDITURES	
Total Federal Spending	$2,983
Less Spending by Trusts with Dedicated Revenues	
Old Age and Survivors Insurance	(516.2)
Disability Insurance	(109.0)
Hospital Insurance	(235.6)
Supplemental Medical Insurance	(232.6)
Railroad Retirement Board	(10.4)
HI/SMI Funding from General Revenues*	184.8
Net Federal General Spending	**2,011.7**
Individual income taxes less dedicated payroll taxes as percent of total general spending	**70.761%**

Note: *HI/SMI spending paid from general revenue sources are retained in calculation of federal government's aggregate "General Spending"

The Mean, Median and Modal Distribution of Federal-Taxpayer Burdens

For the purposes of the immediate calculation I define a federal-taxpayer as a non-poor adult over the age of 18 and earning at least twice the federal poverty line ($21,200 for a family of four).[98] The Census Bureau estimated that 161 million individual Americans fit this profile.

[98] In a quantitative study of Medicaid costs presented in the previous chapter I use the states' adult population with incomes of at least 100% of the federal poverty as a proxy for the number of taxpayers. This lowering of the threshold was necessary of practical limitations imposed by the available time series data, but seems theoretically appropriate over the larger time frame of the study, given the fact that a much greater proportion of Americans owed a net tax liability to Washington in the Eighties and Nineties compared to present. For example, in 1993 (the earliest date such estimates are available), the threshold at which a family of four was estimated to owe net federal taxes was $15,600 and the federal poverty guideline was $14,350. Twenty-four percent of all federal tax filers had no liability

This proxy seems plausible and sufficiently robust, if still somewhat of an overestimation of the actual number of federal taxpayers. For the 2008 tax year, Scott Hodge (2010) of the non-partisan tax research group, *The Tax Foundation,* estimated that after factoring in the affect of the major elements of the Economic Stimulus Act of 2008 (P.L. 110-185), the income threshold at which point a married couple with two children had a positive tax liability was $56,700. In the absence of the stimulus rebates, the threshold would have been roughly $44,500—which is still slightly higher than twice the Federal Poverty Guidelines for 2008 (i.e. $21,200 = 100% of FPL for a family of 4).

Using this subpopulation as the denominator for calculating the average public cost of all Medicaid/CHIP spending by the federal government the result is $1,280 per taxpaying adult with a household income greater than twice poverty in 2008. It might be arguable that this reflects the true opportunity cost of Medicaid/CHIP—that is the total savings that could be used for other public services if the federal payments for program were fully eliminated.

But if the objective, as it happens to be, is to calculate a better measure of the direct costs to taxpaying Americans for the nation's redistributive spending on Medicaid, it is necessary to recognize that that the individual income taxes paid by this subpopulation financed only 70.8 percent of the federal government's total spending commitments, including Medicaid/CHIP. With this adjustment, the mean federal-taxpayer burden of financing the nation's federal commitment to Medicaid/CHIP was $876 in 2008.

This estimation of a taxpayer's burden, however, is significantly higher than what the median taxpayer contributes. Given the progressivity of federal income taxes any estimate of the mean taxpayers' burden for the federal government's public spending will vastly overstate the direct liability paid by a

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in 1993, compared to 36 percent of filers in 2008. Throughout the 1980s the percentage of returns with no net tax liability averaged less than 20 percent, suggesting that the income threshold was even closer to the federal poverty line in the 1980s than in the 1990s (Hodge 2010).

majority of the taxpaying population while simultaneously understating the very high cost borne by a few Americans. The unequal distribution of income and the progressivity of federal taxes in the United States compound to shift a significant portion of the federal tax burden on to a minority of the public (the flat-rate FICA payroll taxes are excluded from the current discussion). For example, according to data from the IRS' Statistics of Income (SOI) Division the wealthiest 0.1 percent of all Americans paid 20.2 percent of the total income taxes collected by the IRS for 2007. Comparatively, the bottom 50 percent of tax filers, about 70 million households, paid 2.9 percent of aggregate federal tax collections (IRS 2009). The ratio between the average tax liabilities of filers in these two groups is nearly 350 to 1. By extension, the marginal tax burden imposed by Medicaid/CHIP and paid by the majority of taxpaying Americans is significantly less than the numbers presented thus far would indicate.

Based on this data and the Medicaid/CHIP's adjusted federal share of $148.5 billion, the poorest half of federal tax filing households paid an average of just $61 each toward the federal government's commitment to Medicaid/CHIP ($148.5 billion × 0.029 ÷ *70.5 million*[99]). Aggregated together these households contributed just 2.1 percent of Medicaid's total federal share. Americans who were among these bottom 50% of earners contributed $61 toward the federal government's Medicaid/CHIP commitment, the equivalent of 0.4 percent of their gross income.

The average rate for the next quartile (the top 50% through 25% of income earners) had a Medicaid burden equivalent to 0.9 percent of their income.

[99] According to 2007 income tax data, the most recent data available (as of October 2010), the SOI Division estimated there to be 141 million tax filers who had a positive tax liability, net of all exemptions and deductions but inclusive of FICA payroll tax contributions (*Ibid*). (As the IRS' estimate of tax filers counts a married couple filing jointly as a single tax filer and includes payroll taxes, their count is not too far off from the proxy of 161 million American taxpayers I computed based on twice the poverty line.) While I could leverage the IRS' data, computing on the basis of taxpaying household would prevent any comparative analyses at the state level where only poverty data is available.

The median *taxpayer*, with an income of $32,879, would fall precisely between this group and the next percentile group. Therefore, if I assume the median federal-taxpayer (with an income of $32,879) paid somewhere between 0.40 and 0.90 percent of their income, the median federal-taxpayer contributed somewhere between approximately $130 and $300 toward the federal-share of Medicaid/CHIP in 2008. At the other end of the income distribution, the top 0.1 percent of earners (i.e. households with adjusted gross income of at least $2 million) who paid 20 percent of the nation's total federal income taxes and were liable for nearly 15 percent of the total federal spending on Medicaid/CHIP financed an average of $212,550 per tax filer of federal Medicaid expenditures.

Figure 7.1 displays the average federal-taxpayer burden imposed by Medicaid's federal share for various percentiles of the nation's income distribution (the relative widths of the columns indicate the aggregate proportion of the federal taxes paid by the earners in the group). **Table 7.2** details the average taxpayer liability and the portion of Medicaid's federal-share paid by of each percentile as well as data related to the adjusted income and federal taxes. For example, a household earning about $250,000 in gross income would have approximately $5,000 of their net federal income taxes redistributed to Medicaid.

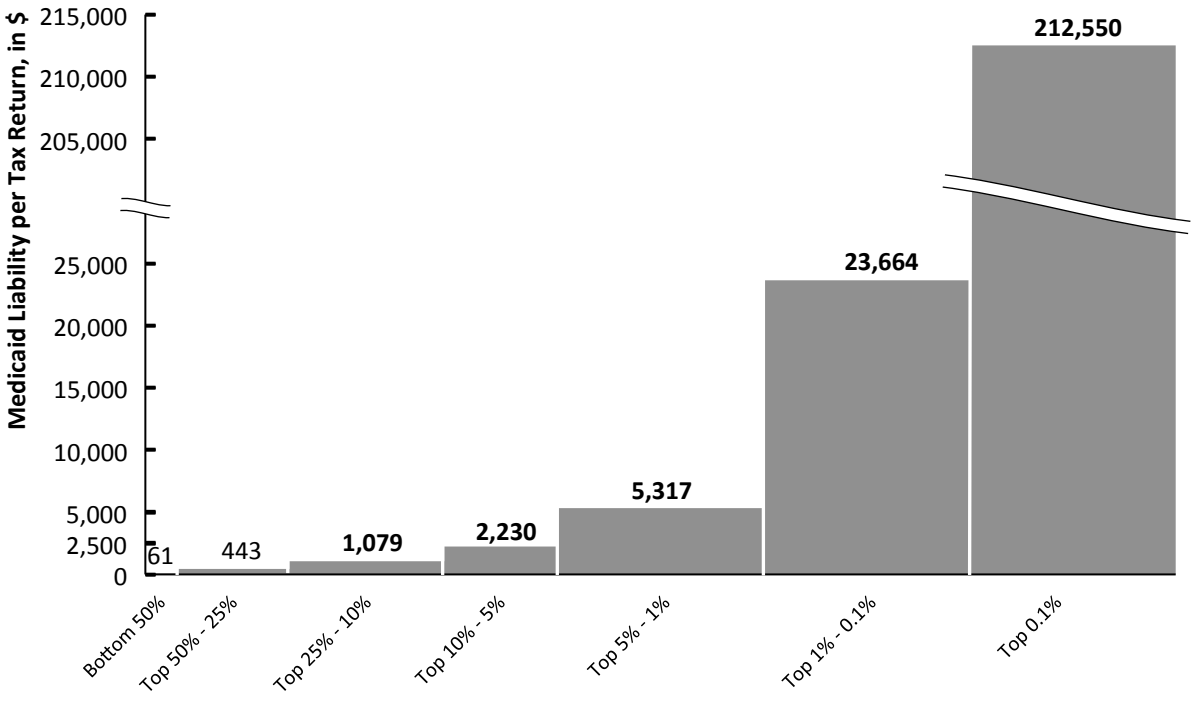
Table 7.2. Distribution of Personal Incomes, Federal Incomes Taxes and Federal Medicaid Liability per Tax Return by Adjusted Gross Income ("AGI") Percentiles, 2010 data

Percentile	Bottom 50%	Top 50% through 25%	Top 25% through 10%	Top 10% - 5%	Top 5% - %1	Top 1% - 0.9%	Top 0.1%
# of Returns with Positive AGI	70,535,485	35,267,743	21,160,646	7,053,548	5,642,839	1,269,639	141,071
Range of AGI	<$32,879	$32,879 - 66,531	$66,532 - 113,017	$113,018 - 160,040	$160,141- 410,096	$410,096 - 2,155,364	>$2,155,364
Average AGI	**15,287**	**47,490**	**85,891**	**132,316**	**227,950**	**755,255**	**7,438,510**
Share of Total AGI (%)	12.26	19.04	20.66	10.61	14.62	10.90	11.93
Average Income Tax Rate (%)	2.99	14.03	15.98	18.79	20.53	22.45	21.46
Share of Income Taxes (%)	2.90	10.52	15.38	10.59	20.20	20.23	20.19
Total Medicaid Liability (millions)	4,295	15,624	22,823	15,727	30,002	30,044	29,985
Share of Total Medicaid Liability	2.06	7.50	10.95	7.55	14.40	14.42	14.39

Avg. Federal Medicaid Liability	61	443	1,079	2,230	5,317	23,664	212,550

Sources: Medicaid Data from Kaiser Family Foundation (2010); Tax data for CY 2007 from I.R.S Tax Services

Figure 7.1 Distribution of Federal Share of Medicaid Liability per Tax Return by Adjusted Gross Income ("AGI"), 2008



Sources: Medicaid/CHIP data from Kaiser Family Foundation (2010); tax data from IRS Tax Services (2009)
Note: The width of the columns reflect the proportion of federal share paid by the income percentile

The State-Taxpayer Burden of Medicaid/CHIP

If a state were to eliminate entirely its Medicaid and CHIP programs the potential taxpayer savings would be limited to the nominal value of the state-share. State residents would see no direct relief in their personal federal tax liabilities as a result of the marginal drop in net federal Medicaid expenditures attributed to the elimination of the state Medicaid program.

As the program is jointly funded and jointly administered by the federal and state governments, it is a valid concern as to whether or not the FMAP formula and federal-state cost sharing properly distributes

Medicaid's public costs in a manner that reflects the policy preferences of Americans. While state residents can more-or-less control the fiscal burden of the state-share of Medicaid/CHIP spending (by enticing their elected officials to adjust eligibility and benefits), the residents have a limited capacity, if any, to adjust their liability for the aggregate federal-share.

Given the broad discretion granted the states and the open entitlement nature of the programs that guarantee federal funding and prevent the CMS from arbitrarily limiting reimbursements to any state, without a fundamental reform to Title XIX (Medicaid) or Title XXI (CHIP) there is no way for a state delegation to limit its constituents' federal tax burden for the nation's Medicaid/CHIP commitments. Thus, from the perspective of taxpayer equity, the emphasis on the variation and redistribution of net federal-taxpayer burden is justified because it is largely exogenous to any individual state's policy calculus.

Comparatively, the state-level taxpayer burden of financing the state-share of Medicaid/CHIP spending commitments can be assumed to be a reflection of the median policy preference of the state's voters. As a result, a certain degree of variation in the state-shares is expected and desirable from the perspective of state-taxpayer preferences for different levels of redistributive spending.[100]

As a case in point compare Massachusetts and Missouri. It is reasonable to assume the median voter in Massachusetts, a state having passed health reform in 2006 that mandated that individuals be insured and that most businesses offer insurance to their workers or face penalties, would prefer greater Medicaid/CHIP spending than the median voter in Missouri, a state that voted 71.1 percent (in August 2010) in favor of the ballot measure intended to block the federal government from requiring Missourians to buy health insurance or punishing the uninsured. Indeed, differences in the Medicaid programs of the two states may appropriately reflect these two states' median voters' contrasting policy preferences for

[100] I acknowledge any claims of equity may be less meaningful from the perspective of potential recipients and/or providers who would qualify for public care or be paid more generously in one state compared to another.

government involvement in health care: in 2008 Medicaid's state-share spending averaged $1,118 per resident in Massachusetts and about half that amount, at $604 per resident, in Missouri.

Yet, absent a normative argument about an appropriate provision of health care, there is little justification to either rein in Massachusetts' altruism or compel Missouri to commit more to Medicaid. On the one hand, Massachusetts—which spent an average of $8,798 per Medicaid recipient and had 18.9 percent of its residents insured by Medicaid at some time in 2008—remained a net contributor of federal revenues relative to its own federal-share of Medicaid reimbursements and so its generosity imposed no great externalities on conservative taxpayers elsewhere in the nation, including Missouri. On the other hand, Missouri's Medicaid program—that insured 17.9 percent of its residents at an average cost of $6,726 per recipient—was about average for the nation and so it is difficult to argue that the state's policies were inequitable to either providers or the poor. As a result of Missouri's higher FMAP rate (63.71 percent compared to Massachusetts' 50 percent), the two states did not differ in terms of their substantive policies as much as might be expected given their respective state-shares.

Calculating the State-Taxpayer Burden of Medicaid

Accepting that a certain level of variability in state policies is legitimate, it remains to calculate what state-taxpayers pay for their state-share of their respective Medicaid/CHIP program. Similar to the calculation of the federal-taxpayer burden of the federal-share, a state-taxpayer's burden is determined not just be the state's overall funding commitment and the state's FMAP rate, but also by the states' specific revenue generating mechanisms and the consequent distribution of public liability among residents.

The states (and their local subgovernments) differ with the US Treasury in how they raise public revenues in at least three significant ways.

First, a larger proportion of a state's residents contribute to their state's share of Medicaid spending than they do to the federal-share of Medicaid spending. Unlike the federal government that generally funds about three-quarters of its total public spending with a highly progressive income tax, only seven states collect more than half of their revenues from individual income taxes (seven states actually have no individual income tax at all, while another two states limit income taxes to just dividend earnings and interest income).

Fearing an exodus of capital and high income earners, the states instead rely upon a variety of revenue sources—including general sales taxes, cigarette and alcohol taxes, property taxes, and select user fees—that tend to be much less progressive (if not categorically regressive). Indeed, after factoring in state and local taxes, the Center for Tax Justice noted, "The U.S. tax system is not as progressive as you think" (McIntyre 2009). Similarly, researchers at the Institute on Taxation and Economic Policy concluded, "[N]early every state and local tax system takes a much greater share of income from middle- and low-income families than from the wealthy" (Davis et al. 2009: 1). Thus, whereas it was appropriate to calculate the federal-taxpayer burden based on the IRS' distribution of tax receipts by income-level, I calculate the state-taxpayer cost of Medicaid per adult resident. Nationally, state spending on the state-share of Medicaid averaged $597 per adult in fiscal year 2008, ranging from $242 (in Alabama) to $1,603 (in New York).

Second, states must pay, or at least budget, for their current operating expenditures and so it is reasonable to ignore any incidental deficit financing that would justify reducing the state share to reflect the proportion of Medicaid expenditures funded by current revenues. Whereas former Vice President Dick Cheney could famously chide, "Deficits don't matter," every state, except for Vermont, has a constitutional or statutory requirement for maintaining a balanced budget. (Admittedly, in 2009 and 2010 this rationale for ignoring state deficits was weakened by the near-universal deficit financing that reached over half of total

state spending in some states. Still, the opportunity cost of any public spending at the state-level still generally remains more visceral than at the federal level where deficit spending is the norm.)

Third, unlike the federal government that has, for the most part, given up on import duties as a means to raise any significant amount of revenues from non-Americans, the states successfully export their tax burden. As early as the 1960s, researchers found that states were extracting between 15 and 35 percent of their operating revenues from non-residents (McLure, 1967). Recent research by the Tax Foundation (2010) similarly evidenced that the beggar-thy-neighbor effort continues.

In its study, the Tax Foundation estimated the total state and local taxes that the average state resident paid both to its own state and to the other states. Using this data as well as data from the U.S. Census' on state populations and state and local governments' own-source general revenues, I estimate a proxy for the percentage of total state revenues financed by a state's own residents.[101] This percentage is used to estimate the state-share of Medicaid/CHIP spending paid directly by a state's own residents.

In 2008, the average state successfully "exported" over half of its revenues and collected only 41.5 percent of total state and local revenues directly from its own residents. In-state collection rates ranged from a low of 6.1 percent of revenues in resource-rich Alaska to a high of 60.8 percent in Maryland.[102]

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[101] The Tax Foundation data does not include an estimate of the total taxes collected by the state and local governments and so to calculate the percentage of revenues paid instate by a state's residents I multiply *(a)* the per capita estimate of the state and local taxes paid by a state's own residents and, *(b)* that state's total population and then divide the product by, *(c)* the US Census' estimate of the total own-source revenues collected by the state and its local governmental units.

[102] Examples of the Tax Foundation's accounting of state revenues paid by in-state residents

Alaska

- has no sales tax nor does it levy an income tax (some cities have sales tax)
- public revenues almost entirely derived from petroleum industry
- **Tax Foundation:** 6 percent of revenues paid by in-state residents

New York

- income tax rates range from 4 percent to 6.85 percent over five income brackets
- 4% state sales tax, with net sales tax exceeding 8% in some areas
- lots of corporate profits and tourists paying in-state tax (e.g. 5.875% hotel tax)

Table 7.3 (available at the end of chapter) includes the data used to compute the share of revenues paid for directly by a state's residents.

Similar to the exclusion of corporate taxes and deficit financing from the estimation of the proportion of Medicaid's federal-share paid for by individual Americans, these in-state revenue percentages are employed as proxies of the proportion of the states' state-share of Medicaid/CHIP spending financed directly by their own residents.

Of course, from a budgetary perspective, the full state-share of Medicaid/CHIP remains the state's real cost for the program. Given the zero-sum nature of state budgets and minimal deficit financing, more so than is the case with the federal budget, a state's Medicaid commitments impose a credible opportunity cost, regardless of the proportion of Medicaid's revenues that come directly from the state's own residents' wallets. In financing Medicaid, the state implicitly prioritizes the poor's access to health care over competing public demands; that is, any funding allotted for Medicaid's state-share could have alternatively financed new public infrastructure projects, greater police protection, smaller class sizes and higher teacher pay, or, in Alaska's case, larger rebate checks for all residents.

Between 1980 and 2008, the average share of state's own-source revenues (i.e. excluding all intergovernmental revenue transfers such as TANF or No Child Left Behind payment or federally-financed infrastructure projects) going to pay for the Medicaid has increased from 6.6 percent to 15.3 percent. The share of state budgets going to everything from education, corrections, infrastructure and general administration have fallen correspondingly.

Situations in which states have cut other public programs while expanding Medicaid can be found across the nation. For example, were it not for the marginal cost of the additional Medicaid commitment made by Arizona to its poorest residents just since 2001, the state would not have had to cut its higher

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- **Tax Foundation:** 50 percent of revenues paid by in-state resident

education budget and force its public universities to raise the tuition rates by upwards of 20 percent and to impose a mandatory furlough on university employees in fiscal year 2009. During the congressional debates over Education Jobs and Medicaid Assistance Act of 2010, Senator Lamar Alexander (R, Tenn.) decried the pattern in which, "Governors and legislatures that have less State revenues continue to increase their spending on Medicaid, not on other programs such as public colleges and universities" (*Congressional Record—Senate,* August 4, 2010, p. S6565).[103]

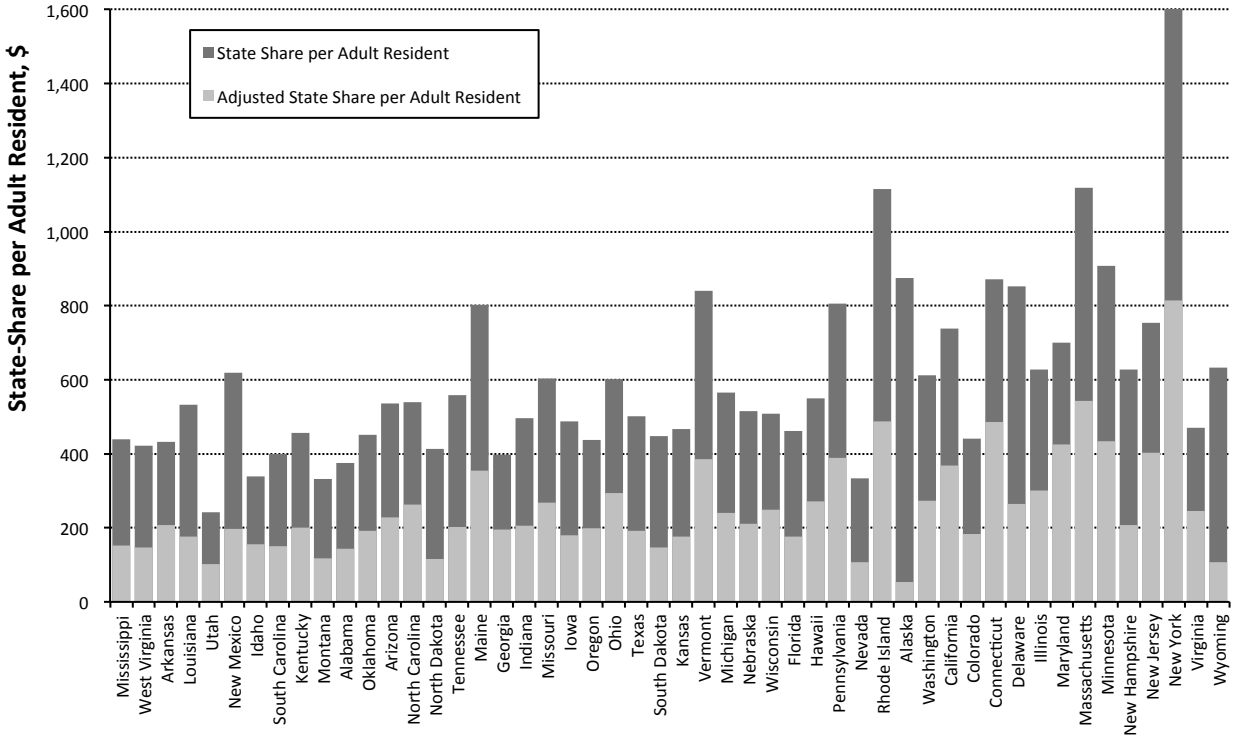
Figure 7.2 overlays the proportion of the state-share of Medicaid/CHIP financed directly by the state's residents over the total spending on the state-share, on per adult resident basis. In relationship to Medicaid the availability of alternative sources of states' revenues has a significant impact on state-taxpayer's direct burden. Alaska, for example, had the ninth most expensive state-share of Medicaid spending in the nation at $640 per capita. Yet, with neither a state sales taxes nor an individual income tax—instead Alaska raised 94 percent of its revenues from the oil and gas industry and not directly from Alaskans—it is misleading to suggest that a typical Alaskan contributed much toward the total $480 million in state revenues committed to Medicaid/CHIP. Rather, after adjusting for just the proportion of Alaska's revenues paid in-state by residents, the state-share of Medicaid that was paid directly by Alaskans was reduced to just $29 million. And at $39 per adult, the direct cost of Alaska's state-level commitment became the least burdensome in the nation.

If the average per adult cost estimated above is assumed to reflect the state-level tax burden of an American earning the nation's median income, then the net taxpayer burden of Medicaid across the 50 states can be roughly approximated by summing the variable state-taxpayer burden presented in **Figure 7.2**

[103] Senator Alexander went on to question the public's tacit support for this high spending on Medicaid. "I am sure the students protesting at the University of California over the 32 percent tuition hikes have no idea the reason they are having the hikes is because Washington keeps imposing new costs on State Medicaid Programs," hypothesized Senator Lamar. "Causing Governor Schwarzenegger and the California Legislature to take money that otherwise most likely would have gone to the University of California and spend it instead on Medicaid" (*ibid*).

with the $130 to $300 federal-taxpayer burden estimated in the previous section. For example, an Ohioan earning about $33,000 could estimate his contribution to Medicaid/CHIP to between $425 and $595 (i.e. the $294 adjusted state-share plus $130-300 adjusted federal share).

Figure 7.2. State-Share and Adjusted (for proportion of state tax revenues paid by in-state residents) State-Share of Medicaid/CHIP Spending per Adult Resident, FY 2008



Note: States are ordered left-to-right with respect to highest to lowest FMAP rate

Table 7.3. Demographics and State/Local/Federal Tax Burdens, by State, CY 2008 (Revenues)

State	Population (1000)	Adult Population (1000)	Adult Population > 200% FPL (1000)	Per Capita Income ($)	State & Local Revenues, excl. Federal Transfers ($million)	State & Local Taxes Paid by In-State Residents ($ per capita)	Share of State & Local Revenues Financed In-State by Residents (%)	Federal Individual Income Taxes Paid by State's Residents ($million)	Share of Total Federal Income Taxes Paid by State's Residents (%)
Alabama	4,716	3,598	2,474	36,372	24,396	1,977	38.22	21,938	0.96
Alaska	672	492	389	44,872	15,908	1,433	6.05	4,360	0.19
Arizona	6,529	4,796	3,224	38,174	33,207	2,170	42.67	32,009	1.40
Arkansas	2,822	2,116	1,340	33,395	13,639	2,315	47.90	20,985	0.92
California	36,637	27,231	18,844	47,706	270,097	3,683	49.96	268,462	11.74
Colorado	4,908	3,701	2,841	48,300	31,589	2,684	41.70	41,964	1.84
Connecticut	3,433	2,615	2,080	63,160	27,705	4,498	55.74	46,710	2.04
Delaware	861	653	485	44,889	6,551	2,364	31.07	12,761	0.56
Florida	18,022	14,002	9,636	46,293	112,800	2,384	38.09	125,090	5.47
Georgia	9,541	7,015	4,755	37,850	49,853	2,579	49.36	57,924	2.53
Hawaii	1,255	970	753	46,512	9,372	3,699	49.53	7,501	0.33
Idaho	1,515	1,099	763	36,492	7,870	2,374	45.70	8,084	0.35
Illinois	12,687	9,507	7,049	46,693	78,144	2,948	47.86	110,521	4.83
Indiana	6,288	4,701	3,341	37,279	35,680	2,348	41.38	38,213	1.67
Iowa	2,986	2,275	1,703	38,636	18,333	2,263	36.86	17,167	0.75
Kansas	2,716	2,017	1,449	40,784	17,644	2,460	37.87	18,629	0.81
Kentucky	4,246	3,236	2,086	34,339	21,217	2,201	44.05	22,840	1.00
Louisiana	4,326	3,208	1,997	39,116	27,215	2,093	33.27	32,375	1.42
Maine	1,317	1,044	749	38,309	8,074	2,701	44.06	6,041	0.26
Maryland	5,528	4,195	3,282	52,709	36,943	4,062	60.78	48,907	2.14
Massachusetts	6,420	4,966	3,830	56,661	47,700	3,609	48.57	72,230	3.16
Michigan	9,806	7,434	5,388	39,273	58,241	2,536	42.70	60,809	2.66
Minnesota	5,120	3,889	3,046	46,106	35,546	3,328	47.94	63,161	2.76
Mississippi	2,900	2,121	1,300	31,836	14,896	1,773	34.52	10,767	0.47
Missouri	5,861	4,457	3,136	38,084	29,916	2,261	44.30	41,039	1.80
Montana	973	757	518	36,793	5,393	1,960	35.36	4,404	0.19
Nebraska	1,774	1,322	988	40,499	11,334	2,611	40.87	13,777	0.60
Nevada	2,581	1,910	1,448	49,371	15,755	1,952	31.98	15,848	0.69
New Hampshire	1,300	1,004	822	48,033	7,185	1,824	33.00	10,304	0.45
New Jersey	8,515	6,480	5,000	56,116	69,828	4,376	53.36	101,061	4.42
New Mexico	1,977	1,470	895	36,031	12,705	2,051	31.92	8,898	0.39
New York	19,309	14,965	10,655	55,032	184,106	4,845	50.81	192,567	8.42
North Carolina	9,234	6,936	4,642	37,508	49,377	2,597	48.57	60,045	2.63
North Dakota	625	480	350	39,612	4,816	2,167	28.12	3,684	0.16
Ohio	11,386	8,644	6,159	38,925	68,534	2,937	48.79	95,002	4.16
Oklahoma	3,550	2,650	1,890	38,415	18,991	2,280	42.62	19,755	0.86
Oregon	3,806	2,936	2,076	39,444	21,326	2,538	45.29	23,778	1.04
Pennsylvania	12,178	9,420	7,074	43,796	76,931	3,054	48.34	100,088	4.38
Rhode Island	1,042	808	604	44,463	6,901	2,900	43.78	8,475	0.37
South Carolina	4,462	3,398	2,249	35,419	24,265	2,048	37.66	18,850	0.82
South Dakota	794	599	439	39,103	3,959	1,645	32.99	4,613	0.20
Tennessee	6,163	4,710	3,037	38,090	30,354	1,779	36.12	43,752	1.91
Texas	24,174	17,411	11,464	42,796	131,113	2,082	38.39	178,762	7.82
Utah	2,754	1,892	1,485	35,971	15,122	2,305	41.98	14,200	0.62
Vermont	610	483	355	42,626	4,087	3,072	45.86	3,456	0.15
Virginia	7,735	5,873	4,477	47,666	48,595	3,281	52.22	54,324	2.38
Washington	6,526	4,979	3,741	48,574	43,369	2,957	44.50	53,831	2.35
West Virginia	1,796	1,412	942	32,145	10,137	1,982	35.12	6,183	0.27
Wisconsin	5,548	4,222	3,130	40,953	34,623	3,047	48.82	38,456	1.68
Wyoming	529	397	295	53,163	6,040	1,925	16.86	3,940	0.17

Table 7.3 (Continued). Federal/State Medicaid Cost and Spending Metrics, by State, FY 2008

State	Federal-Share Spending ($ per Capita)	Adjusted Cost for State's Share of Federal-Share ($ per Adult Resident > 200% FPL)	State-Share Spending ($ per Capita)	Adjusted Cost (for In-State Tax Burden) of State-Share ($ per Adult)	Total Spending ($ thousands)	Total Adjusted Cost ($ thousands)	Share of Total Paid by Current Taxpayers (%)
Alabama	608	572	287	110	4,219,107	1,872,046	44.37
Alaska	717	724	640	39	911,781	295,356	32.39
Arizona	779	641	394	168	7,662,692	3,075,510	40.14
Arkansas	890	1,011	325	155	3,426,808	1,734,971	50.63
California	563	920	548	274	40,714,415	26,615,459	65.37
Colorado	340	954	332	138	3,296,251	3,271,576	99.25
Connecticut	669	1,450	664	370	4,576,547	4,155,293	90.80
Delaware	651	1,699	646	201	1,117,067	961,156	86.04
Florida	478	838	358	137	15,080,929	10,187,521	67.55
Georgia	509	786	292	144	7,640,757	4,952,990	64.82
Hawaii	557	643	424	210	1,232,026	727,169	59.02
Idaho	580	684	246	113	1,252,111	669,884	53.50
Illinois	480	1,012	470	225	12,053,523	9,679,442	80.30
Indiana	630	738	371	153	6,289,986	3,325,190	52.86
Iowa	606	651	371	137	2,919,670	1,469,070	50.32
Kansas	515	830	347	131	2,341,137	1,507,355	64.39
Kentucky	812	707	348	153	4,923,098	2,061,626	41.88
Louisiana	1,053	1,047	395	131	6,264,884	2,568,252	40.99
Maine	1,108	521	636	280	2,298,116	742,445	32.31
Maryland	544	962	531	323	5,941,000	4,804,696	80.87
Massachusetts	883	1,218	865	420	11,222,400	7,158,764	63.79
Michigan	601	729	428	183	10,091,808	5,548,678	54.98
Minnesota	695	1,339	689	330	7,087,486	5,592,423	78.91
Mississippi	1,052	535	321	111	3,983,144	986,845	24.78
Missouri	769	845	459	204	7,198,248	3,727,918	51.79
Montana	572	549	258	91	808,174	360,894	44.66
Nebraska	540	900	384	157	1,638,634	1,129,586	68.93
Nevada	280	707	247	79	1,360,086	1,182,969	86.98
New Hampshire	492	809	485	160	1,269,965	844,536	66.50
New Jersey	591	1,305	574	306	9,922,137	8,850,257	89.20
New Mexico	1,157	642	460	147	3,197,846	840,105	26.27
New York	1,250	1,167	1,242	631	48,121,371	24,083,146	50.05
North Carolina	731	835	405	197	10,489,842	5,527,058	52.69
North Dakota	567	680	317	89	552,460	283,345	51.29
Ohio	717	996	457	223	13,367,829	8,408,035	62.90
Oklahoma	697	675	336	143	3,667,992	1,729,229	47.14
Oregon	532	739	338	153	3,311,820	2,051,108	61.93
Pennsylvania	741	913	623	301	16,601,275	9,847,962	59.32
Rhode Island	981	906	864	378	1,922,781	917,826	47.73
South Carolina	707	541	304	114	4,509,874	1,674,993	37.14
South Dakota	515	678	338	111	677,193	373,371	55.14
Tennessee	754	930	427	154	7,280,157	3,652,833	50.18
Texas	566	1,007	361	139	22,425,487	14,396,324	64.20
Utah	407	617	166	70	1,579,602	1,069,383	67.70
Vermont	1,035	629	665	305	1,036,885	399,541	38.53
Virginia	365	783	357	187	5,585,643	4,798,434	85.91
Washington	503	929	467	208	6,335,976	4,682,649	73.91
West Virginia	962	424	331	116	2,322,552	590,761	25.44
Wisconsin	532	793	387	189	5,096,251	3,423,375	67.17
Wyoming	482	862	475	80	506,148	285,690	56.44

Sources: State Tax Data from Tax Foundation (2010), Federal Revenue and Tax Data from IRS Tax Services (2010), Medicaid Data from Kaiser (2010)

The Interstate Redistribution of Federal Taxes and Medicaid/CHIP

The previous sections estimated individual proxies for Medicaid's federal- and state-taxpayer burden. Whereas the taxpayers' state-share is determined by the Medicaid/CHIP spending of the state in which they live and its revenue generating mechanisms, the uniformity of federal income tax brackets across the United States means that two individuals of comparable wealth will pay the same federal taxes and contribute comparably toward the federal-share of Medicaid/CHIP.

Due to the progressivity of the federal tax code, however, a poor state inhabited by a disproportionately large number of poor individuals will pay far fewer federal taxes in the aggregate and on average per taxpayer than a rich state that has a greater share of wealthy residents. With state per capita incomes ranging from $31,836 in Mississippi to $63,160 in Connecticut in 2008, the distribution of federal taxes paid per capita varies widely across the fifty states. Indeed, with respect to the states' federal individual income tax collections, Mississippi paid an average of $5,076 per capita compared to $17,862 per capita in Connecticut. Based on the respective poverty levels and distribution of incomes of these two states it is reasonable to extrapolate that their median federal tax liabilities would exhibit even greater variation.

Federal redistributive programs, such as Medicaid/CHIP, are generally intended to take revenues collected from rich states and subsidize the delivery of public services to residents living in poorer states. The income-adjusted FMAP formula compounds the progressive transfer of federal tax dollars from rich states to poor states by lowering the marginal cost of a dollar of expenditures in a poor state relative to a rich state. This interstate redistribution of federal revenues is intended to lower the potential horizontal inequity in state-level tax rates and/or benefits that would otherwise result from the states different abilities to finance their Medicaid commitments.

Thomas Grannemann and Mark Pauly (2010), however, argue that deficiencies in Medicaid/CHIP's cost sharing formula and Medicaid's limitless entitlement financing oblige the taxpayers in comparatively poor (and, generally, conservative) states to subsidize the state-level policy decisions of their wealthy (and, typically, liberal) neighbors. The authors argue this limits the effectiveness of the program to redistribute revenues to poor states. As evidence for the taxpayer inequities imposed by Medicaid, they computed the net interstate transfer of federal revenues used to finance the federal-share of Medicaid. They "calculate [a state's] contribution to the federal funding [of Medicaid] by assuming its share is proportional to its share of aggregate federal personal income taxes" and then "subtract the imputed contribution toward Medicaid paid in federal taxes from the federal Medicaid payments provided to the states" (2010: 140). The authors then designated any state that received from Washington at least a billion dollars more in Medicaid transfer than the state contributed in taxes toward the total federal-share of Medicaid spending as a 'receiver'; a state that contributed at least a billion dollars more in federal taxes than it received in Medicaid funding was a 'donor' state; and states netting either a marginal gain or loss of plus/minus billion dollars was 'about-even'.

To demonstrate Grannemann and Pauly's metric and exemplify the potential for real taxpayer inequities as identified by them, compare New York and Georgia. In addition to differing in terms of state and per capita income and, therefore, the general federal taxpayer burden of their residents, New York and Georgia also represent the opposite extremes for the potential generosity and frugality of Medicaid/CHIP. From most perspectives New York has one of the most generous programs in the nation, both in terms of its eligibility criteria and the benefits it delivered: at a total cost of $48.1 billion, or $2,492 per resident, the state insured 4.9 million residents with Medicaid (about 1.7 times the number of residents in poverty) at an average cost of $9,780 per Medicaid enrollee in 2008. In contrast, Georgia spent a total of $7.3 billion on

Medicaid/CHIP, or just $801 per resident, to insure 1.7 million (a population equivalent in size to 1.1 times the number of poor) at an average cost of $4,286 per recipient.

Based on New York's residents' proportional share of all federal income tax revenues paid in 2008, Grannemann and Pauly's metric would have attributed 8.4 percent, or $16.8 billion, of the $207 billion total federal share of Medicaid/CHIP reimbursements to the federal taxes paid by New Yorkers. The federal government, however, reimbursed New York $24.1 billion. Even with the minimal FMAP rate of 0.50, New York netted $7.3 billion in Medicaid/CHIP funding above what its residents paid in taxes underwriting the federal-share of Medicaid/CHIP. Comparatively, Georgians paid 2.5 percent of all federal individual income taxes collected and therefore financed $5.2 billion of the federal government's spending on Medicaid/CHIP, but received just $4.9 billion in Medicaid/CHIP transfers. Despite a federal matching rate of 63.10 percent for Medicaid (and 74.17 percent for CHIP) that augmented every dollar that came from the state's own resources with nearly three federal dollars the state's taxpayers actually suffered a net loss of $300 million in federal Medicaid/CHIP-related funds.[104]

Admittedly, both New York and Georgia are exceptional in their Medicaid programs. But, are Grannemann and Pauly justified to conclude that Medicaid's federal-state cost sharing not only subsidized the largesse of certain rich states, such as New York (the fourth wealthiest state on the basis of per capita income), but actually redistributed wealth out of some of the nation's poorest states? From this perspective,

[104] Had Georgia provided Medicaid coverage and benefits comparable to New York, Georgia's total Medicaid spending would have increased to $25.8 billion, with the federal government subsidizing the state $16.3 billion, for a net gain of $11.0 billion in federal Medicaid/CHIP related funds (although the conditional state-share that would have had to been financed by state residents would also increase—to $9.5 billion). And if every state similarly resembled New York then the nation's total spending on health care for the poor would approach a staggering $700 billion, with the FMAP-adjusted federal-share reimbursed by the national treasury topping $400 billion, double the current federal Medicaid expenditure for 2008. Conversely, if all states, including New York, provided Medicaid coverage and average benefits equivalent to Georgia's comparatively frugal levels, total Medicaid-related spending in the United States would fall by about forty percentage points to $200 billion, with the federal-share costing national taxpayers approximately $115 billion.

it appears that Georgia, despite recouping three our of every five dollars it spent on Medicaid, could have actually been better off it it had borne the entire liability of its Medicaid program itself and its residents were allowed to recoup the full share of federal tax dollars contributed to nation's spending on Medicaid.

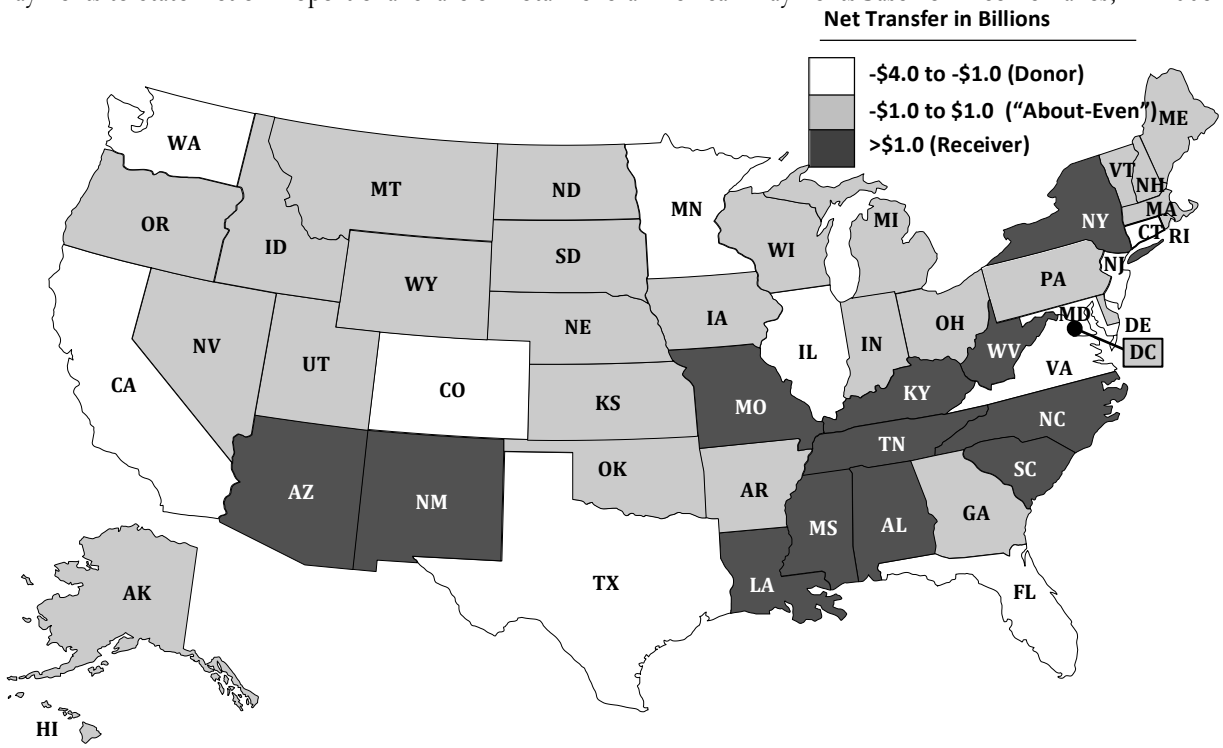
Figure 7.3 replicates the state-by-state analysis of Grannemann and Pauly (2010), using FY 2008 data from the Center for Medicare and Medicaid. The results are consistent with the authors' findings; although the magnitudes of the transfers are slightly attenuated in 2008 compared to 2006. Overall, the map and numbers shows that the redistributive effect of all the shuffling of federal funds is quite minimal with the majority of states coming out 'about-even.' New York is a relative anomaly with most of the comparatively wealthy states being classified as either "about-even" or "donors."[105] Aside from New York, the nation's fifteen wealthiest states remained net contributors to Medicaid/CHIP's federal-share. And, as the authors acknowledge, "part of [the redistribution into New York] can be viewed as a transfer within the New York-New Jersey-Connecticut tri-state area" (p. 143) with both New Jersey and Connecticut classified as generous 'donor' states.

Indeed, as evidenced by the dark columns in **Figure 7.4** that aggregate the state-level transfers over the four main census regions, the Northeast region, which includes New York and its wealthy neighbors, saw a net interregional transfer of $2.7 billion—less than 1.5 percent of total federal spending on Medicaid/CHIP. Despite the authors' criticism of the purported taxpayer inequity caused by Medicaid/CHIP's cost sharing, the nation's poorest states in the South saw the greatest aggregate gain from Medicaid with a net federal transfer of $4.1 billion into the region. This later redistribution being the result of the region's higher than average FMAP rates that augmented the progressivity of the federal income tax

[105] However, to put the interstate transfer of revenues *into* New York in perspective, I believe it is worth noting that although New York may have benefited in this instance from Medicaid's federal-state cost sharing, the state remains a net contributor of federal taxes, generally losing out on 21 cents in federal transfers for every dollar its residents contributed in federal taxes (based on 2005 data; Tax Foundation 2007).

and returned to the poorest southern states as much as four or five dollars of federal aid for every dollar in state revenues they spent on their Medicaid/CHIP programs.

Figure 7.3. Donor, Receiver, and 'About-Even' States Based on Aggregate Dollar Amounts of Federal Medicaid Payments to State Net of Proportional Share of Total Federal Medicaid Payments based on Income Taxes, FY 2008



Sources: based on Grannemann and Pauly 2010: 141 (Figure 6-2); data from Kaiser Family Foundation (2010) and US Internal Revenue Service (2010)

Note: Example of Pauly and Granneman's calculation of the net transfer of federal revenues attributable to federal income taxes paid by state residents and total federal spending on Medicaid/CHIP

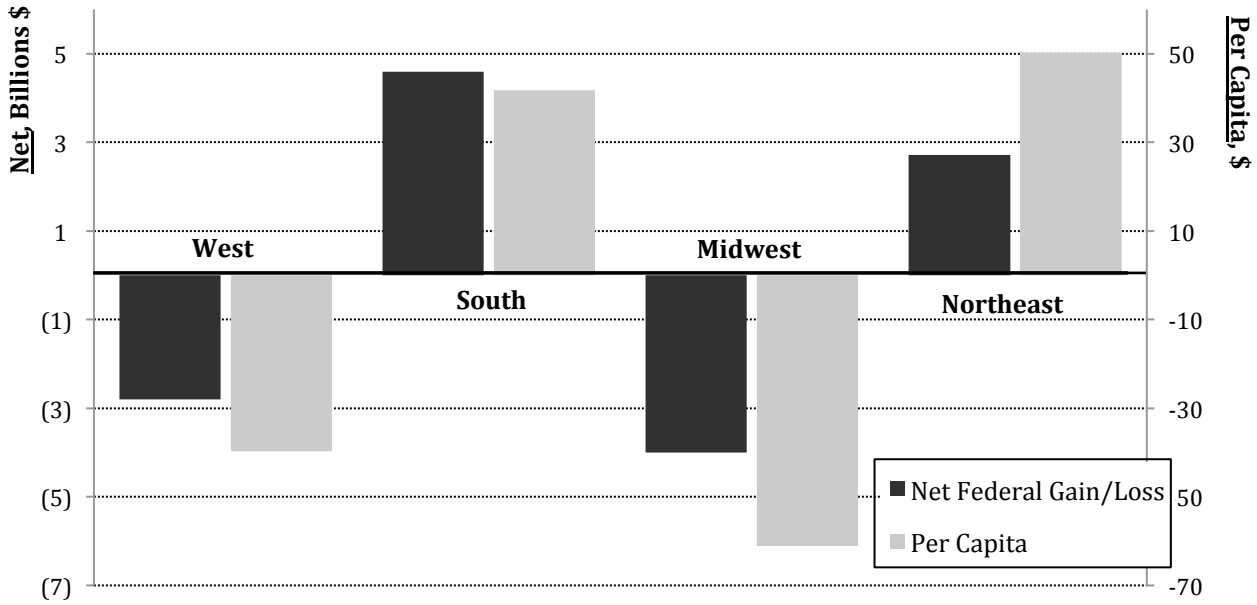
Michigan

- Total Medicaid/CHIP Expenditures in MI = $10.5 billion
  - State-Share = $4.2 billion
  - Federal-Share = $6.3 billion

  Calculation of MI's Proportional Share of Total Federal Spending on Medicaid/CHIP
  - Michigan's Share of Total Federal Personal Income Taxes Collected = 2.9%
  - Total Federal Spending on Medicaid/CHIP = $199 billion
  - Therefore, MI's Contribution to Total Federal Spending on Medicaid/CHIP
    = 0.029 × $199 billion = $5.8 billion

    Note: *If MI were to cease participation in Medicaid/CHIP altogether its residents would still contribute $5.6 billion toward the federal-share of Medicaid/CHIP expenditures through their federal income taxes, i.e.* 0.029 × *($199 billion – $6.3 billion)*
- MI's net transfer of federal revenues associated with Medicaid/CHIP
  = $6.3 billion - $5.8 billion = + $500 million (i.e. "about even")

Figure 7.4. Interregional Transfers of Federal Individual Income Taxes Due to Medicaid/CHIP, by Census Region, FY 2008



Sources: based on Grannemann and Pauly 2010: 141 (Figure 6-2); data from Kaiser Family Foundation (2010) and US Internal Revenue Service (2010)

Critique of Grannemann and Pauly

Grannemann and Pauly's observations that "Medicaid's redistributive effect toward the lower-income states is a modest one" and that its federal cost sharing "does not consistently benefit all lower-income states" (p. 144) holds for the 2008 data. However, there are two problems with their methodology for calculating interstate transfer of federal revenues associated with Medicaid's taxpayer burden that superficially influence their findings and the implications thereof.

First, given the considerable differences in state populations it is more appropriate to present the states' federal share of Medicaid costs on a per capita or per taxpayer basis instead of on an absolute basis. The implications of not controlling for a state's population size can be significant. For example, Grannemann and Pauly's metric classified both Delaware and Maine as "about-even." But after controlling

for the states' populations, Delaware appears as the nation's most generous interstate "donor" with a net contribution of $642 per capita.[106] Meanwhile, Maine becomes the second highest "receiver" of Medicaid/CHIP federal funding with a net gain of $708 each.

Second, Grannemann and Pauly's calculations assume that federal individual income taxes are the only source of funding available for Medicaid redistribution, despite being only a proportion of total federal revenues collected. Grannemann and Pauly explain that their metric is based exclusively on a state's share of the total personal income taxes paid to the IRS because "other federal taxes (such as corporate income taxes) are less clearly attributable as a contribution of the state's residents" (2010: 140). Corporations, for example, generally file in a single state despite often having business operations span across the nation. However, by not adjusting from their calculations for those taxes that they consciously exclude, Grannemann and Pauly overstate the degree to which Medicaid/CHIP are financed by individual income taxes. This leads to them both overestimating the amount paid directly by the residents in each state and underestimating the return that the states receive from the federal government for their Medicaid/CHIP programs.[107]

[106] Similarly, the $500 million transfer out of Delaware is much more significant than a $2.8 billion transfer out of California. California is the most generous "Donor" state according to Grannemann and Pauly's aggregate metric, but after controlling for population the state is seen to distribute only $76 per resident, less than the average "about-even" state.

[107] Grannemann and Pauly's metric also includes all dedicated FICA payroll taxes. These dedicated taxes are more regressive in nature than regular income taxes and so they account for a greater proportion of the federal revenues collected from lower income states compared to wealthier states. Excluding these payroll taxes will lead to lower income states appearing to be recipients of a marginally greater federal Medicaid transfer, relative to their uncommitted general revenue contribution. Unfortunately, the IRS' accounting of state-level individual income tax receipts is net of all FICA taxes and thus the same data limitations that would not have allowed Grannemann and Pauly to differentiate the amount of FICA taxes paid in each state also prevent me from fully corroborating the hypothesis that excluding payroll taxes would show a marginal redistribution of federal revenues from rich to poor states.

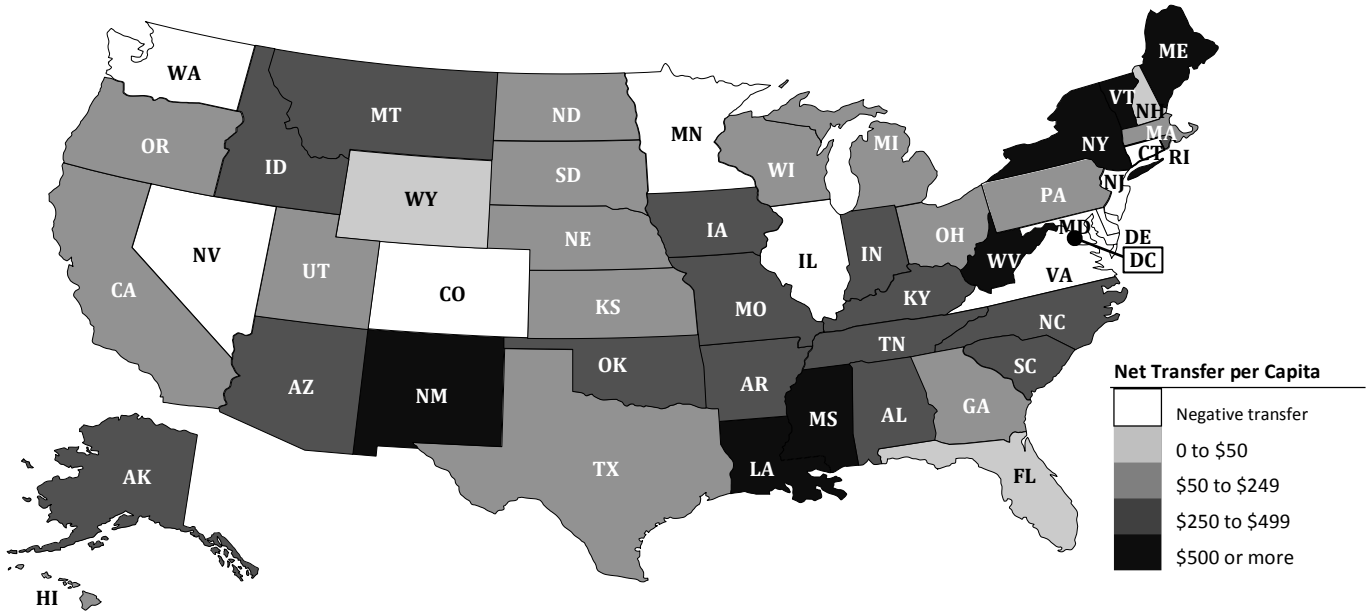
To address these two concerns, I replicate Grannemann and Pauly's metric using the percentage of general spending financed directly by the uncommitted tax receipts of Americans (i.e. 70.8 percent, as calculated above to exclude dedicated payroll taxes), thereby matching the $145.8 billion in taxpayer-financed Medicaid contributions with the full $206.1 billion in federal Medicaid reimbursements. Given what effectively is a 30 percent subsidy across the nation, it is unsurprising that every census region was the recipient of significantly more in Medicaid funding than it directly funded. Only ten states and the District of Columbia continued to contribute more in personal income taxes than they received in federal Medicaid reimbursements.

Making these two adjustments to Grannemann and Pauly's methodology provides modest evidence that federal matching formula positively improved horizontal taxpayer equity and redistributed the fiscal burden of Medicaid of the poorer states to wealthier ones—albeit not necessarily to the extent intended. The 10 states that continued to have net redistribution included the nation's three wealthiest states—Maryland, New Jersey and Connecticut. And all ten of these states had low FMAP rates, with only Nevada, with a FMAP rate of 52.64 percent, having a rate higher the statutory minimum. **Figure 7.5** re-presents the state-level redistribution of federal revenues associated with Medicaid/CHIP expenditures, but adjusts the state-level contributions to the federal-share to reflect the proportion of federal revenues paid for with personal federal income taxes from the state's residents. **Figure 7.6** aggregates the per capita and total Medicaid-related redistribution by census region, comparing it to the unadjusted amounts.

Despite finding some of Grannemann and Pauly's evidentiary support to be attenuated with a few simple and reasonable corrections to their metric, the authors' broader critique of Medicaid's federal-state cost sharing and the ineffectiveness of the FMAP rates remain compelling. Certainly, the cost sharing aspect of Medicaid's funding mechanisms hides its true public cost and has the potential to contribute to Medicaid-

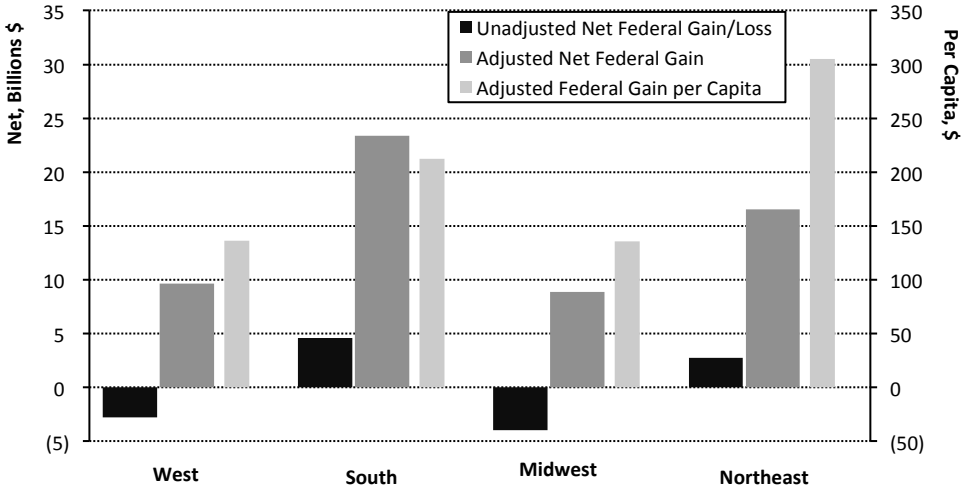
related inefficiencies (if not inequities). Reforming the FMAP formula to reflect more than a state's per capita income could reduce these problems. This is left for a later discussion, however.

Figure 7.5. Per Capita Distribution of Federal Medicaid Payments Received Net of Contribution toward Federal-Share of Medicaid (relative to Individual Income Taxes Paid), by State, FY2008



Sources: data from Kaiser Family Foundation (2010) and US Internal Revenue Service (2010)

Figure 7.6. Net/Per Capita Distribution of Federal Revenues for Medicaid/CHIP, by Census Region, FY2008



Sources: "Unadjusted Net Federal Gain/Loss" from Figure 4 above, chart based on Grannemann and Pauly 2010: 143 (Figure 6-3); data from Kaiser Family Foundation (2010) and US Internal Revenue Service (2010)

Notes: "Unadjusted" Gain/Loss replicates Grannemann and Pauly (2010) methodology (see Figure 7.3 above). "Adjusted Gain" considers only the transfer of federal revenues attributable to federal income taxes

The States' Net Return on their Medicaid/CHIP Expenditures

This final section considers the states' net return on their direct investments in Medicaid/CHIP. To do so, I sum the state-share paid in-state by residents (i.e. employing the Tax Foundation data introduced above that excludes those taxes 'exported' to nonresidents) and the state's net contributions to the federal-share of Medicaid. This sum is then used to derive an estimate of the proportion of a state's total Medicaid spending paid directly by the state's residents. On average, state residents directly finance what would be equivalent to approximately 60 percent of the total spending on Medicaid/CHIP in their state.

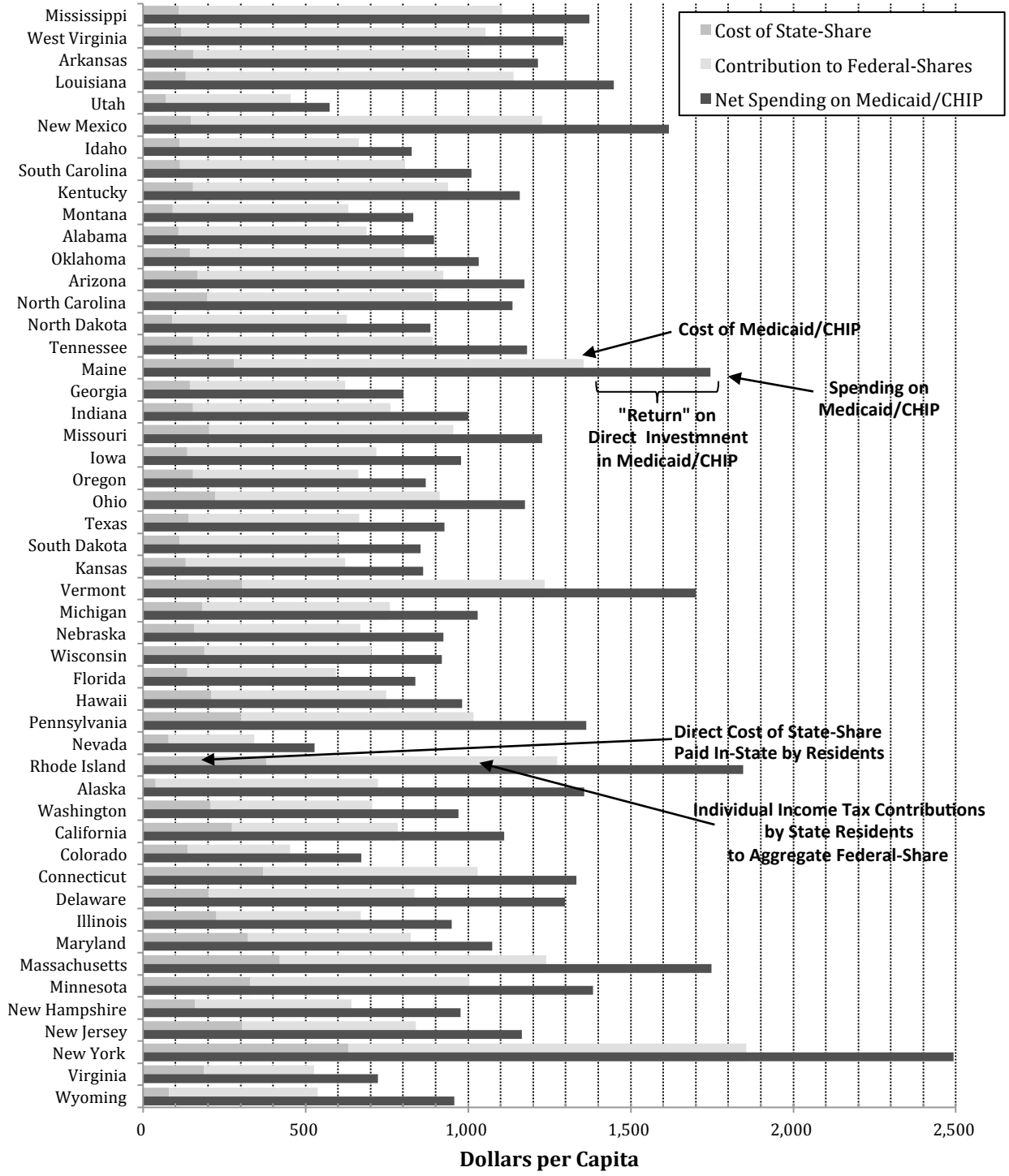
Americans, however, can only impact their own state's commitment to the program. So it is significant that the direct cost of the state-share of Medicaid/CHIP is less still, at just 5 to 25 percent of the total state spending on Medicaid/CHIP in the state. This is the only portion of the aggregate tax burden associated with Medicaid/CHIP that residents and their state legislators have any amount of real control over. While Medicaid is one of the costliest domestic programs in a state's budget, states have little incentive to decrease their spending on Medicaid because any direct savings would be minimal relative to the sizeable reduction in benefits required of the cuts.

Alaska with its low state-level taxes is an extreme case, but if Alaska eliminated their program in an act of conservative activism, Alaskans would see their direct tax liability drop by just $39 per adult. The state would still be on the hook for contributing nearly $350 million (about $869 per federal-taxpaying Alaskan) toward the nation's federal spending on Medicaid/CHIP. Further, the state would lose $430 million in transfer payments—money that would have gone directly into the pockets of doctors and hospitals.

Figure 7.7 presents the proportion of each state's Medicaid/CHIP commitment financed with state- and federal-taxes paid by a state's residents (see also the last column of **Table 7.3**). The states are listed from top to bottom, from lowest to highest per capita income, with the bottom 13 states all having an FMAP rate of 0.50 percent. Over half of the states pay less than 60 percent of the aggregate cost of their state's Medicaid/CHIP program. Ten states directly finance more than 70 percent of their own spending—and every one of those states has per capita incomes above the national average. Only Colorado approached 100 percent of cost, but is both an outlier and relatively wealthy, with an FMAP rate of 50 percent. **Table 7.4** synthesizes the information presented in the figure and offers the average and minimum and maximum of the various measures of Medicaid costs.

In examining the funding sources of Medicaid/CHIP what emerges is a picture that median-income-earning Americans across the fifty states get a pretty decent return on their tax dollars with respect to Medicaid/CHIP. While it may seem counterintuitive given the extreme cost of the Medicaid/CHIP programs, the taxpayer burden of the program, at least for the median taxpayer, is comparatively low relative to the benefits the states' derive. While the diffusion of costs is not sufficient explanation for Medicaid/CHIP—AFDC with its comparable funding structure and similar diffusion of costs incited public outrage and has seen no growth in funding commitments over the past decades—it does offer a partial explanation for the resiliency of Medicaid/CHIP spending.

Figure 7.7 Comparing Medicaid/CHIP's per Capita Costs and Spending, by State, FY 2008



Note: **Cost of Medicaid/CHIP**$_i$ = state-share$_i$+state share of federal income taxes$_i$ × $\sum^{n=50}$ federal-share$_i$

Table 7.4. Various Metrics Estimating the Federal- and State-Share of Medicaid/CHIP Spending, by State, FY 2008

Federal-Share		
Federal Spending per Capita		$662
Cost of Federal-Share per Taxpayer[X]		1,239
Adjusted Cost[Y] *of Federal-Share per Taxpayer*[X]		876
State-Share, by State		
State Spending per Capita	Min	$166
	Median	453
	Max	1,242
Cost of State-Share per Adult Resident	Min	$242
	Median	597
	Max	1,603
Adjusted Cost[Y] *of State-Share per Adult Resident*	Min	$39
	Median	191
	Max	631
Total Medicaid/CHIP, by State		
Total Spending per Capita	Min	$527
	Median	1,129
	Max	2,492
Total Cost per Adult Resident	Min	$767
	Median	1,402
	Max	3,249
Total Adjusted Cost[Y] *per Adult Resident*	Min	$553
	Median	1,057
	Max	1,931

Notes: [X]: Taxpayer is defined as an individual at least 18 and with household income of twice the FPL

[Y]: Adjusted for personal income taxes as share of total federal spending (excluding programs with dedicated revenue sources), based Tax Foundation's estimate of in-state tax revenues (i.e. 70.8 percent for FY 2008)

SECTION IV.

CHAPTER 8:

Conclusion

The preceding chapters have explored in considerable detail the political development of Medicaid's cost sharing formula and the affects of the Federal Medicaid Assistance Percentages (FMAP) on the states' Medicaid budgets. Both qualitatively and quantitatively the dissertation has provided evidence identifying this funding mechanism as one of the critical factors contributing to the nation's high level of welfare spending on health care. With the federal match reducing the fiscal burden of a state's Medicaid program, state policymakers are incentivized to repeatedly expand eligibility and enrich benefits for Medicaid. With the inflationary affect of such policy reforms Compounded over decades the result has been a level of public spending on the health care needs of the poor that contradicts the common assumption that Americans generally prefer a modest welfare state.

I have argued that Medicaid's cost sharing formula is designed to obfuscate the program's total costs and compel states to participate more generously in the program than they would otherwise. Similar to how subprime mortgages wrecked havoc on household savings and the housing sector by enticing families to spend more on a home than they would otherwise, the states' FMAP rates have led the states to spend significantly more on Medicaid than is optimal given the states' limited finances. Indeed, rising Medicaid costs have affected the states' spending priorities and have necessitated that the states reduce their spending on other public commitments and/or impose higher tax collections. The average proportion of the states' general operating funds needed to finance the state share of Medicaid has increased from less than 2% in

1966 to 5% in 1980 and then to 13% in 2008[108] (see Figure 3.5 and Figure 4.2). Similarly, total Medicaid spending as a share of the states' total budget has increased from 9% in 1980 to 24% in 2008. As a result of the growth in Medicaid, by the early nineties, the states were spending more on Medicaid than on higher education; and, now, many states spend more on Medicaid than they do on K-12 education.[109] It is not surprising that Governor Evan Bayh of Idaho (D), quoted in Chapter 5, lamented, "Health care is destroying state government." (Shribman 1993)

The game theoretic model known as the prisoner's dilemma, introduced in the final section of Chapter 1, provides a prescient theory for the inflationary tendency of Medicaid and recognition of the opportunity cost of both the state and federal shares. In the absence of cooperation between the states to set limits to their own budgets, the model explains how and why federal cost sharing compels states to increase spending on Medicaid beyond what is preferred by Americans. In game theoretic terms, the states' Medicaid budgets reflect a Pareto inefficient Nash equilibrium, meaning that although no state would rationally pursue an alternative strategy of a more limited Medicaid program given their residents preferences, most Americans would strictly prefer it every state, including there own, had more limited Medicaid budgets than what is currently reflected by the status quo. This is the paradox created by the status quo funding mechanism for Medicaid that redistributes fiscal liabilities.

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[108] The state share declined in 2009 to 12.5% of the state's own-source revenues, despite an increase in overall Medicaid spending, due to the a increase in the temporary increase in the states' FMAP rates passed by Congress in response to the national recession.)

[109] Personally, as an academic, I am particularly sensitive to the contrast in how the states' prioritized the maintenance of their Medicaid budgets over their higher education commitments in the five years following the Great Recession of 2008-09. For example, whereas the states' spent an average of 28 percent *less* on higher education in 2013 than in 2008—with many public universities having been forced to dramatically raise their tuition rates or cut staff and faculty (Oliff et al 2013)—the states spent at least 40 percent *more* on Medicaid/CHIP over that same period (using projections for fiscal year 2013 from the Center for Medicare and Medicaid Services). Of course, Medicaid is a countercyclical program and so there is the expectation that the program will experience higher costs during a weak economy.

Irrespective of the federal share, as long as the marginal benefit derived from the Medicaid spending in a state exceeds the direct marginal cost associated with the state share, the budget is rational. For example, the state of Michigan had a FMAP rate of 58.1 percent for FY 2008—meaning dollar the fiscal burden of a$1 million investment in Medicaid is "just" $420,000 in state revenues. So long as Michigan residents preferred an additional million dollars in Medicaid expenditures to a $420,000 increase in taxes or a $420,000 reduction in spending elsewhere in the budget, the prioritization of additional Medicaid spending would be rational. Overall, the Michigan residents are better off having this larger Medicaid budget than either maintaining the status quo or pursuing some alternative expenditure. For the most part, Michigan residents should be unconcerned with the indirect costs associated with the financing of either its own federal share or the nation's cumulative federal share because Michigan's own policy will have no meaningful affect on total federal spending.

Yet, federal spending is financed with income taxes paid by state residents. As such, the federal shares are not strictly exogenous to either a state's residents or the state's budget. As federal taxpayers the Michigan residents should be concerned about not only their own state's federal share but, more importantly, every states' federal share. Admittedly, emphasizing the financial implications of federal spending on a state's budget and its residents' income taxes is contrarian. For example, a fact sheet prepared for the Center for Children and Families at Georgetown University refutes the endogeneity of Medicaid financing to the state's federal share with its authors arguing, "[W]hen considering how Medicaid spending impacts state budgets and other priorities for state dollars, it is more accurate to examine state spending, rather than total (state and federal) spending" (Heberlein and Alker: 2011, pp. 1-2). Although I distinguish between the fiscal burden of the state share and the total cost of a state's Medicaid program throughout this dissertation I think ignoring the cost of Medicaid's federal share effectively underestimates the opportunity cost of the program. Given that most state residents also pay federal taxes the size of the

states' cumulative federal share, nearly $200 billion in 2008, is relevant from the perspective of a state's residents.

In Chapter 7 I quantified the full opportunity cost of the states' federal shares by examining how cost sharing affected the net transfers of federal revenues between the states in relationship to their Medicaid programs. Overall, I found that the transfer of funds between the states was remarkably flat, meaning that for most states the opportunity cost of a state's Medicaid program was more or less equivalent to the total cost of that state's own Medicaid program. Again using the example of Michigan, the state's $10.5 billion Medicaid/CHIP program imposed a state fiscal burden of $4.2 billion on Michigan resident in 2008. However, the residents paid federal taxes equivalent to $5.8 billion toward the federal government's spending of $199 billion on Medicaid/CHIP.[110] The total opportunity cost of the nation's Medicaid/CHIP program for Michigan residents was therefore $10 billion, more than double Michigan's state share. When Michigan residents are considering their support for their state's Medicaid programs should they define their preferences in relationship to the $4.2 billion state share financed from the state's general operating fund, or in relationship to the $10 billion opportunity cost of the Medicaid program? Under the status quo funding arrangement, it may be rational for residents and their state representatives to consider only the $4.2 billion state-level investment because the state can do nothing to appreciably affect total federal costs and even if Michigan had no Medicaid program the federal tax liability of Michigan residents would remain unchanged.

The only way to limit total Medicaid's cost and therefore the state residents' net liabilities is for Congress to impose institutional constraints that limit the states' policy choices. Without any federal

[110] I assume all Americans financed the nation's federal spending on Medicaid in relationship to their contribution to the nation's total income tax collections—in total, Michigan residents paid 2.9 percent of federal income taxes collected in 2008 and so I assume they financed a 2.9% share of the nation's total federal spending on Medicaid/CHIP.

intervention, the states will continue to increase spending on Medicaid until the marginal cost of the increase in the state share exceeds the marginal benefit derived from the additional spending. In the past, both Congress and the executive branch have proposed potential solutions. For example, replacing the existing financing mechanism that allows states to draw down unlimited federal funds with a program of federal block grants of capitated state allocations would limit the states' ability to leverage federal dollars and mitigate, but not eliminate the incentives created by the funding formula to commit state resources to Medicaid (see Chapter 4 for block grant proposals presented by President Reagan in 1981 and the Republican-led House in 1995). Alternatively, fully federalizing the program would make Congress accountable to all American taxpayers for the net amount of Medicaid appropriations and eliminate the ability of the states to redistribute costs, thereby leading to a budget that would more likely reflect the preference of the median American (see Chapters 3 and 4 for report of President's Nixon's McNerney Task Force of 1969 and proposal of President Reagan in 1982).

Contrary to such efforts to rebalance the shared responsibility between the states and federal governments for underwriting Medicaid, the federal government has passed reforms, both temporary and permanent, that have seen the absolute and proportional shares of Medicaid expenditures steadily increase. Without any reforms to Medicaid's cost sharing formula to restrain the states' spending, Medicaid/CHIP costs are projected to further increase, exceeding the general rate of inflation ever year and approaching $900 million in expenditures by fiscal year 2020 (Center for Medicare and Medicaid 2013). As a result this means-tested program will continue to supplant the funding available for other state priorities. I hope that in highlighting the FMAP funding formula readers will scrutinize the total opportunity costs associated with the nation's Medicaid spending before its costs become unsustainable.

EPILOGUE:

The Affordable Care Act: Reshaping Medicaid and the Welfare State

After a contentious political debate, President Obama signed comprehensive health reform, the Affordable Care Act ("ACA"), into law on March 23, 2010. The law creates public health insurance exchanges in every state and provides substantial federal subsidies to individuals assist with the cost of purchasing coverage through the exchanges, introduces a requirement that individual maintain health coverage (i.e. the individual mandate) and imposes penalties on some employers who do not offer insurance, modestly reforms Medicare (in particular, Medicare Part D, the prescription drug benefit), and includes a myriad of new regulations on the health insurance industry. With respect to Medicaid, the law extends eligibility to all Americans with incomes less than 133% of the federal poverty line, effectively 138% of FPL after a 5% allowance is factored—for a family of four this is equivalent to an annual income of $32,499. With many states not providing coverage to any nondisabled adults, except pregnant women, unless they are extremely poor, this reform accounts for nearly half of those who are anticipated to gain insurance coverage beginning in 2014 as a direct result of the reforms. According to budget estimates by the CBO, the Medicaid reforms are anticipated to cost a trillion dollars between 2014 and 2022, with the federal government financing 93 percent of the costs over that period (CBO 2012).

On June 28, 2012, the Supreme Court rendered its final decision that upheld the new health care law, with one significant caveat. While a majority of the Court ruled that the individual mandate requiring Americans to be insured to be constitutional, albeit under the federal government's taxing authority not any broader general welfare authority, the Court determined that the ACA's mandatory Medicaid expansion (42 USC § 1396a-c) was unconstitutionally coercive of states and violated basic principles of federalism and

limitations on Congress' spending power (as recognized by the Supreme Court in *South Dakota v. Dole, 483 U.S. 203 (1987*)). The Court explained that Congress could not use its spending power as a means to coerce states into accepting conditions that it could not impose directly by threatening to withhold all federal funding under Medicaid, the nation's single largest grant-in-aid program.

The Chief Justice described "the threatened loss of over 10 percent of a State's overall budget" for not participating in the Medicaid expansion as "economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion" (*National Federation of Independent Business v. Sebelius* 567 U.S. ___ (2012): 52; the case was heard together with *Florida v. Department of Health and Human Services*). Such coercion, Chief Justice Roberts noted, "runs counter to this Nation's system of federalism." Irrespective of the generous "financial 'inducement' Congress has chosen," the withholding of all federal Medicaid funding for noncompliance with the ACA expansion was akin to holding "a gun to the head" of state legislators. (*Ibid.* 51) The Court reasoned that Washington could use the carrot (i.e. dangling new money) but not the stick (i.e. withdrawing old money) to entice state participation in the new program. Given the present magnitude of Medicaid, the Court dismissed the 1965 introduction of Medicaid's broader participatory requirements and concurrent repeal of the then existing system of medical vendor payments as establishing precedent for Congress' inducement for mandatory participation in the Medicaid expansion.[111]

[111] The reader may recall from Chapter 3 how the Social Security Act of 1965 encouraged states to participate in the optional Medicaid program by making it the only avenue for federal assistance for vendor payments. Upon a state's adoption of the Medicaid, but no later than end of 1969, the federal government would no longer fund vendor payments under the various public assistance titles of the Social Security Act (other than Title 19). This is different than the conditionality of the ACA's Medicaid funding for two reasons. First, is the relative scale of the potential impact of the two provisions: federal reimbursements of vendor payments prior to 1965 were insignificant compared to the value of the federal-share of Medicaid payments today (less than 1 percent compared to over 10 percent). Second, the elimination of non-Title 19 vendor payments was not contingent on participating in Medicaid; *every* state would lose non-Medicaid payments, irrespective of their participation in Medicaid. Medicaid would become the *only* program and not be a separate program like Chief Justice Roberts understands the ACA Medicaid expansion to be.

The Court remedied the unconstitutionality of the Medicaid expansion and upheld the broader law by limiting the Health and Human Services (HHS) Secretary's enforcement authority to withhold federal funds to states that do not elect to expand their Medicaid. This effectively made the Medicaid expansion optional. A seven-Justice majority of the Court agreed with this assessment and proposed remedy.

Although the majority opinion accepted that Congress can generally impose conditions on the receipt of federal aid and make adjustments to such conditions—even acknowledging that the original Medicaid statute explicitly gives Congress the "right to alter, amend, or repeal any provision" of the law. (*Ibid* 53, citing 42 U. S. C. §1304)—Chief Justice Roberts argued that this allowance does not apply to the ACA's Medicaid expansion because it is "a new grant program, not an addition to the Medicaid program existing before the ACA's enactment" (*Ibid.* 39). By "threaten[ing] States with the loss of funds from an old program in an effort to get them to adopt a new one" (*Ibid*) Congress was employing financial dependency as a "means of pressuring the States to accept policy changes" (*Ibid.* 50). The Chief Justice opined that by "forc[ing] the States to implement a federal program would threaten the political accountability key to our federal system" (*Ibid.* 48).

To differentiate unconstitutionality of the ACA expansion from the constitutionality of other federal mandates impacting the states' Medicaid programs, Roberts emphasized two features of the ACA expansion that show the reform to be a "a shift in kind, not merely degree" (*Ibid.* 53) and a "transformation" of Medicaid (*Ibid.* 55). First, his majority opinion recognizes that by extending Medicaid coverage to all non-elderly Americans under 133 percent of poverty, the ACA fundamentally changes the demographics of Medicaid. "[Medicaid] is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage," observes the Chief Justice (*Ibid.* 53-54). In comparison to the ACA's more general Medicaid expansion, previous changes to the program's eligibility criteria have been restricted to extending Medicaid coverage to a larger number of

pregnant women and children. As the Chief Justice reflected, "[Previous eligibility reforms] can hardly be described as a major change in a program that—from its inception—provided health care for 'families with dependent children'" (*Ibid.* 55).

Second, and most relevant to the preceding chapters, the majority opinion argues that Congress has created an entirely new social program because it supplants the variable FMAP funding formula with a new funding arrangement. The Court's perspective that the Medicaid expansion reflects a "a shift in kind" is predicated on the argument that the FMAP funding formula is fundamental to not only Medicaid's financing, but also its general administration. "The manner in which the expansion is structured indicates that while Congress may have styled the expansion a mere alteration of existing Medicaid, it recognized it was enlisting the States in a new health care program," observed Chief Justice Roberts (*Ibid.* 54). Even more so than with the introduction in 1996 of the enhanced FMAP rates for SCHIP—itself is an optional welfare program, separate, if still related, to Medicaid—the funding mechanism employed for the Medicaid expansion is an implicit acknowledgement by Congress that no state had the fiscal capacity to implement and finance the nation's health reform agenda under its existing Medicaid program. Whereas the traditional FMAP formula reflects a shared fiscal responsibility loosely related to the states' relative wealth (as measured by the state's per capita income), the constant and more generous federal match proposed to finance the state's Medicaid expansion population is an entirely different funding mechanism that is an implicit acknowledgement by Congress that no state has the fiscal capacity to finance the nation's health reform agenda as part of its existing Medicaid program.

Will the States Participate in Medicaid Expansion?

As a result of the Supreme Court's decision, states have the option of whether or not to go forward with the Medicaid expansion. This could temporarily increase variability in the state's Medicaid

programs.[112] As of October 2013, only 25 states had announced their intentions to expand Medicaid to all nonelderly residents with incomes up to 133 percent of poverty. Twenty states have announced that they will not expand their Medicaid programs and 5 states are still debating the alternatives. Interestingly, the policy of whether or not a state elects to expand its Medicaid program appears to be significantly motivated by partisan politics: of the 26 states moving forward with the Medicaid expansion, only 6 have Republican governors (Arizona, Iowa, Nevada, New Mexico, New Jersey, and Ohio); conversely, of the 26 states either not moving forward with the Medicaid expansion or still debating whether or to expand forward, only 3 have Democrat governors, with political opposition coming exclusively from the Republican-controlled houses of the legislature in those cases (Missouri, Montana, and New Hampshire). The unambiguous correlation between partisanship and a state's decision to extend Medicaid eligibility contrasts remarkably with the results from the quantitative study in **Chapter 6** that found little to no substantive impact of political ideology on Medicaid policymaking.

Despite the initial hesitancy of many conservative states to implement the Medicaid expansion, I anticipate that nearly all states will eventually participate in the ACA Medicaid expansion—if not necessarily at a full 133 percent of poverty.[113] Even discounting the social benefits that come from

[112] In the long term, however, the ACA should motivate a regression to the mean among the states' Medicaid eligibility criteria. On the one hand, the ACA Medicaid expansion encourages all states to raise access to 133-138% of poverty. On the other hand, the introduction of the exchanges and federal tax credits to purchase lower the cost of purchasing private insurance, may encourage some states to lower their Medicaid eligibility criteria for certain individuals above 133-138 percent of poverty in order to lower the state's fiscal burden for Medicaid (ACA Maintenance-of-Effort requirements prevents states from lowering coverage for children and pregnant women).

[113] If allowed by the federal government, some states may elect to set Medicaid eligibility for nonelderly adults at (say) 100 percent of poverty and rely upon the ACA's health benefit exchanges to deliver private insurance to Americans above 100 percent. Beginning in 2014 Americans with incomes between 100 and 400 percent of poverty and purchasing coverage through one of the exchanges will be eligible for federal subsidies to help lower the cost of purchasing private health insurance. While the exchanges were intended to be complement the Medicaid expansion, the Supreme Court's decision making Medicaid expansion options could allow the states to use the exchanges as a substitute for Medicaid coverage, at least for those between 100 and 133 percent of poverty. The monthly cost of

extending insurance coverage to tens if not hundreds of thousands of previously uninsured residents, with the federal government financing a substantial portion of the cost of the expansion, at least through 2020, the fiscal incentives for participation are just too great for states to ignore. Specifically, the states will not pay any cost (aside from 50 percent of associated administrative costs) for the expansion until 2017, at which point the federal government will gradually transition to covering a fixed 90 percent of the cost, irrespective of the state's FMAP rate, through at least 2021. In total, the Congressional Budget Office estimates that the federal commitment to Medicaid will increase by approximately 40 percent, adding approximately $100 billion in additional federal spending by 2020 (assuming participation of all states). Comparatively, the state-share attributed to the ACA expansion population will increase the state's fiscal burden by an average of just 0.8 percent (*Ibid.* 46, 48). It is likely that the states will be able to finance these marginal costs from new revenues that they would accrue from economic activity directly tied to the new federal dollars flowing into the states on behalf of the Medicaid expansion population.

Budget estimates from the states support the view that health reform imposes minimal fiscal burden on the states. Indeed, some states' analyses suggest that by just maintaining the status quo and not expanding Medicaid to include the ACA-eligible population, a state could find itself in a situation in which it faces an increased fiscal burden (for significantly fewer public services) than it would have had the state participated in the expansion.[114] For example, in Kentucky, the state's Cabinet for Health and Family Service estimates that even after assuming 10 percent of the cost of the newly eligible Medicaid recipients "it would cost the state more not to expand [Medicaid] than to expand." According to the Cabinet's

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obtaining coverage for this subpopulation would be equivalent to 2 percent of household income: approximately $25 per month for an individual earning $16,000 a year.

[114] Part of the increased costs could be for state paying for otherwise uncompensated care, previously funded with disproportionate share hospital payments that the ACA limits. The logic behind the restriction in DSH payments being that with a greater number of people insured through Medicaid and/or obtaining private insurance there would be less uncompensated care. Of course, if a state did not expand Medicaid there would likely be a greater amount of uncompensated care than there would be otherwise that the states may be pressured to subsidize (without any federal match).

accounting, upon full implementation of the ACA reforms, Kentucky would see a negative $38.9 million impact to the state's budget in fiscal year 2021 if it did not expand. Comparatively, "expansion would create a $802.4 million positive budget impact from FY14 to FY2" and directly contribute to $15.6 billion in new economic activity in the state, creating nearly 17,000 additional jobs throughout the state (Kentucky Cabinet for Health and Family Services, 2013). In May 2013, Democrat Governor Steve Beshar committed his state to the Medicaid expansion.

Similarly, a report funded by a consortium of nonprofits and Ohio University concluded Kentucky's northern neighbor, Ohio, would see a net gain of $1.8 billion through fiscal year 2021 due to the ACA's Medicaid-related provision. "Medicaid expansion not only pays for itself—it creates a positive state budget impact and creates local fiscal and economic benefits," concluded the report. "State savings due to the Medicaid expansion would exceed the net state costs resulting from the ACA's other provisions." (The Health Foundation of Greater Cincinnati et al., 2013) Despite the Ohio legislature failing three times to pass a bill implementing expansion, the report provides an economic rationale to explain why Republican Governor John Kasich ignored the wishes of the state legislature as well a state budget that forbade expansion and instead used a relatively obscure 7-person committee, the Controlling Board that includes 6 state legislators appointed by both parties and the state's budget director, to obtain authority necessary to implement Medicaid expansion. It would seem that ideological preferences of certain state policymakers for a limited federal government aside, the Medicaid expansion involves too much federal money for the states to leave on the table.

Post-ACA Medicaid

In her partial dissent to the majority's argument that the Medicaid expansion was unconstitutionally coercive, Justice Ruth Ginsburg describes Medicaid as a "federally funded, state-administered program"

(*National Federation of Independent Business v. Sebelius* 567 U.S. ___ (2012): f.n. 17 at 45). Her opinion curiously failed to acknowledge that both state *and* federal governments have traditionally funded Medicaid. Yet, this shared fiscal responsibility has always been fundamental to Medicaid operations. As the nation's largest example of cooperative federalism the mutual responsibility for the cost of implementation has helped maintain, as Chief Justice Roberts observed in the majority opinion, "political accountability" for both partners. This feature is necessary for protecting federal taxpayers and encouraging states to be efficient in how they operate their Medicaid program. Under the traditional FMAP formula the states retain some proverbial skin in the game. The absence of any meaningful cost sharing diminishes the fiscal imperative for states to control their costs. Similar to how some states inappropriately leveraged DSH and UPL payments to reduce the effective fiscal burden of their Medicaid policymaking decisions or to how some states took advantage of CHIP waivers to extend the enhanced FMAP match for coverage beyond the intended population (see GAO 2004), the enhanced funding provided under the Affordable Care Act may motivate states to undertake creative accounting schemes that maximize their federal dollars. Not unlike the quid pro quo of states providing UPL payments to hospitals while simultaneously collecting a provider tax, the opportunity to access to the ACA's match may be too tempting for state policymakers to resist.

Part of the appeal of Medicaid's original cost sharing arrangement is that it minimizes, or at least reduces, the moral hazard of a state being profligate with federal dollars. Although the federal-state cost sharing incentivizes a state to spend more than it would otherwise, a state must still adhere to balance budget laws that bound public officials to a degree of fiscal discipline. Every year or two when these elected officials set their state's budget they must justify to their voters the Medicaid expenditures. For example, if a state desires to raise reimbursement rates or enact an eligibility expansion that increases Medicaid spending by $100 million, the state would need to find between $20 to $50 million in state revenues to finance its share of the expansion. Even if federal cost sharing obfuscates the total cost of Medicaid, voters

are given the opportunity to express their preferences for a more-or-less robust Medicaid program in relationship to their state's other public needs or tax policies.

In contrast, with a state's fiscal burden for the ACA's Medicaid expansion approaching zero (at least in the initial years), proponents of expansion can discount its high national cost and instead strictly emphasize its positive benefits for the states. Similar to the examples set by Kentucky and Ohio, Governor Janice Brewer of Arizona, a fierce opponent of the ACA more generally, successfully lobbied her state legislature to implement the ACA expansion by articulating what a fiscal boon it was for the state. She, like Governor Kasich did in Ohio, emphasized how the state stood to gain nearly $2 billion in Medicaid assistance to cover an additional 300,000 Arizonians and "boost our economy by creating more than 20,000 jobs at a time when Arizona needs them most." It was an opportunity for the state to recapture "the very tax dollars our citizens already pay to the federal government" (Brewer 2013). Such economic arguments rest on the implicit assumption that a state's decision to expand Medicaid will not lead to its residents experiencing any increase in either their taxes or diminution of other public services. With full federal funding this argument is valid across all the states and should entice most rational states to participate in the Medicaid expansion.

Irrespective of a state's decision to expand Medicaid, its expenditures will continue to increase and likely at a pace greater than either general inflation or the growth in state general revenues (as has been the trend of the past half century. Assuming full implementation of the ACA-related reforms the Center for Medicare and Medicaid Services (CMS) projects that Medicaid expenditures will increase by more than 150 percent over the next decade: by 2021 total Medicaid spending is expected to reach almost a $1 trillion and account for at least 20 percent of national health expenditures, up from 15.5 percent in 2010, with the states' share expected to reach $385 billion (CMS 2012). Medicaid is unsustainable in its current form; as the bipartisan State Budget Crisis Task Force succinctly explained in July 2012, "Medicaid spending growth

is crowding out other needs." Yet, if the notion of universal coverage that is embodied in the ACA remains a national goal, our governments—both federal and state—and the people they represent must come to terms with the necessary scale of public spending.[115]

[115] Fortunately, despite its high cost and high fiscal burden, Medicaid, remains the most efficient component of the US health sector and therefore offers an appropriate avenue for expanding coverage. Compared to either Medicare or private health insurance Medicaid is significantly less expansive on a per recipient basis after controlling for the health status of the recipient. The differentials are due primarily to lower reimbursement rates for doctors and hospitals and, when compared to private insurance, lower administrative costs. For example, across all primary and specialty care Medicaid reimbursement rates are an average of one-third less than comparable Medicaid rates (Zuckerman and Goin 2012).

Unfortunately, the deluge of federal funding with little-to-no requirement for the states to share in the cost of their policymaking decisions may reduce the relative cost effectiveness of Medicaid by lessening the fiscal imperative for states to restrain costs. Indeed, the ACA provides 100 percent funding—separate from the 90-100 percent funding for the Medicaid expansion population—for states to temporarily increase their reimbursement rates for primary care physicians paid on behalf of all Medicaid recipients up to the Medicare's allowable rate. An analysis by the Kaiser Family Foundation suggests that the average rate increase for primary care physician will rise 73 percent in 2013 (Zuckerman and Goin 2012).

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